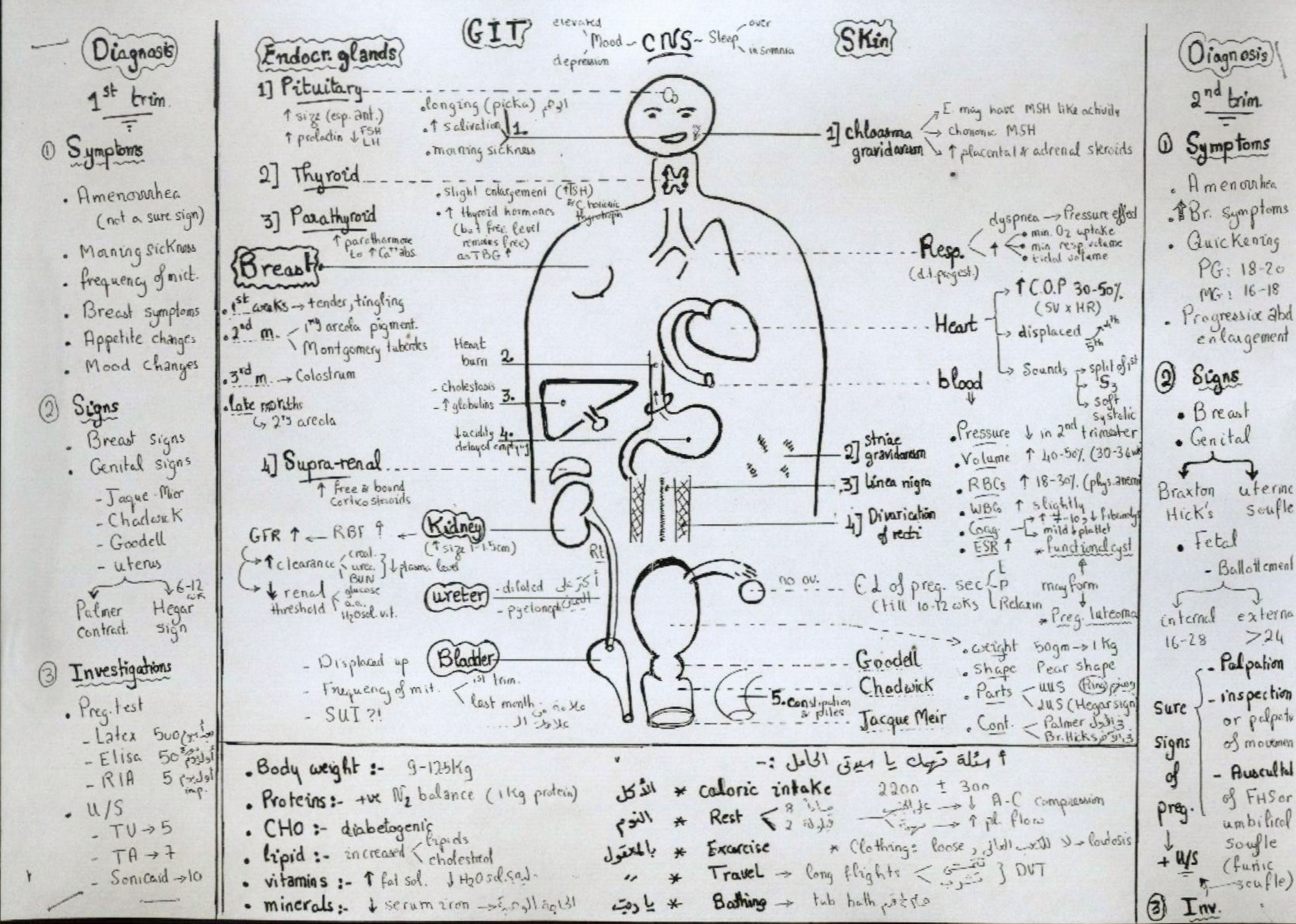
DR. MANDOUH

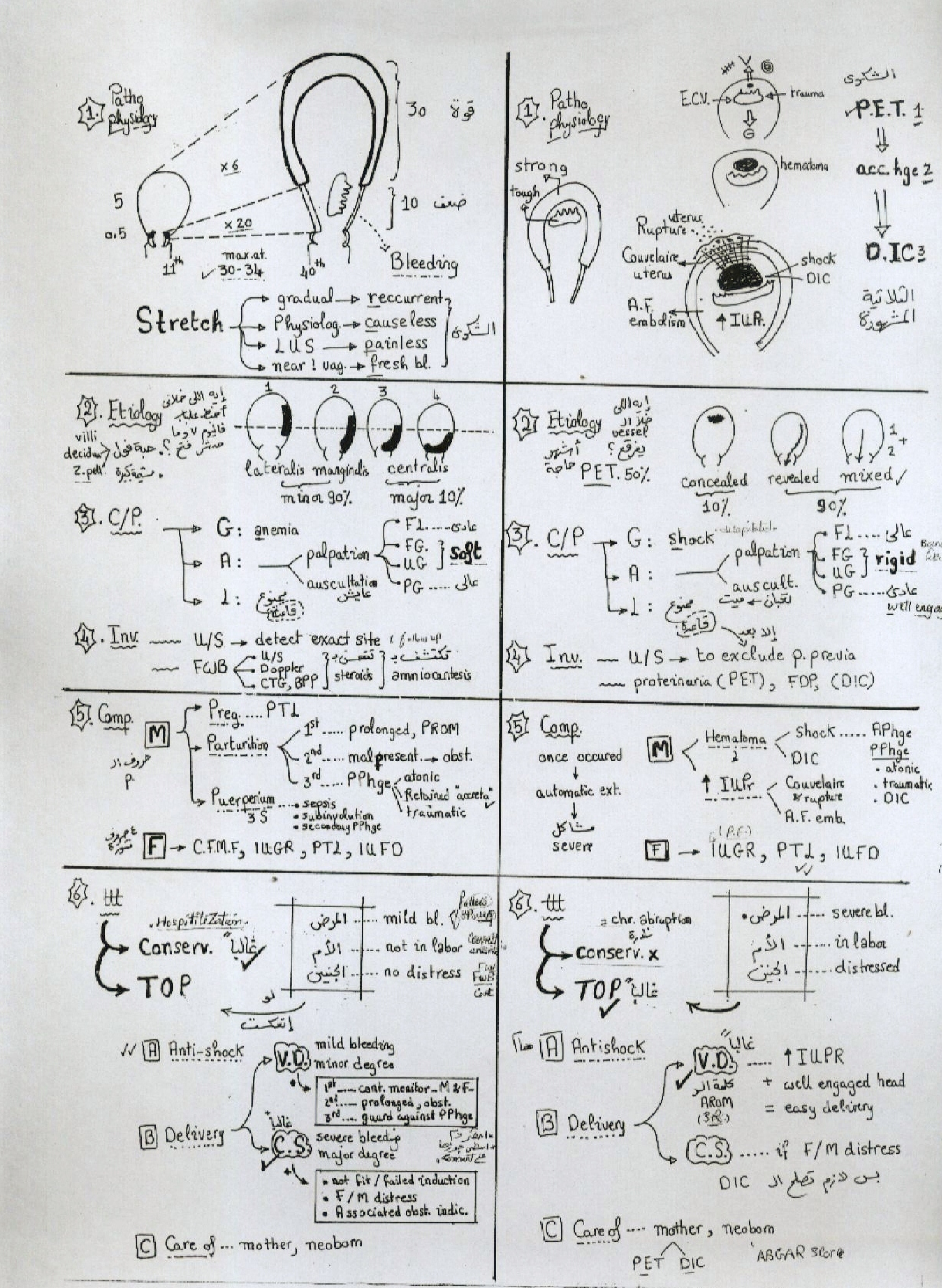
A_3 OBST. REVISION PAPERS

2010

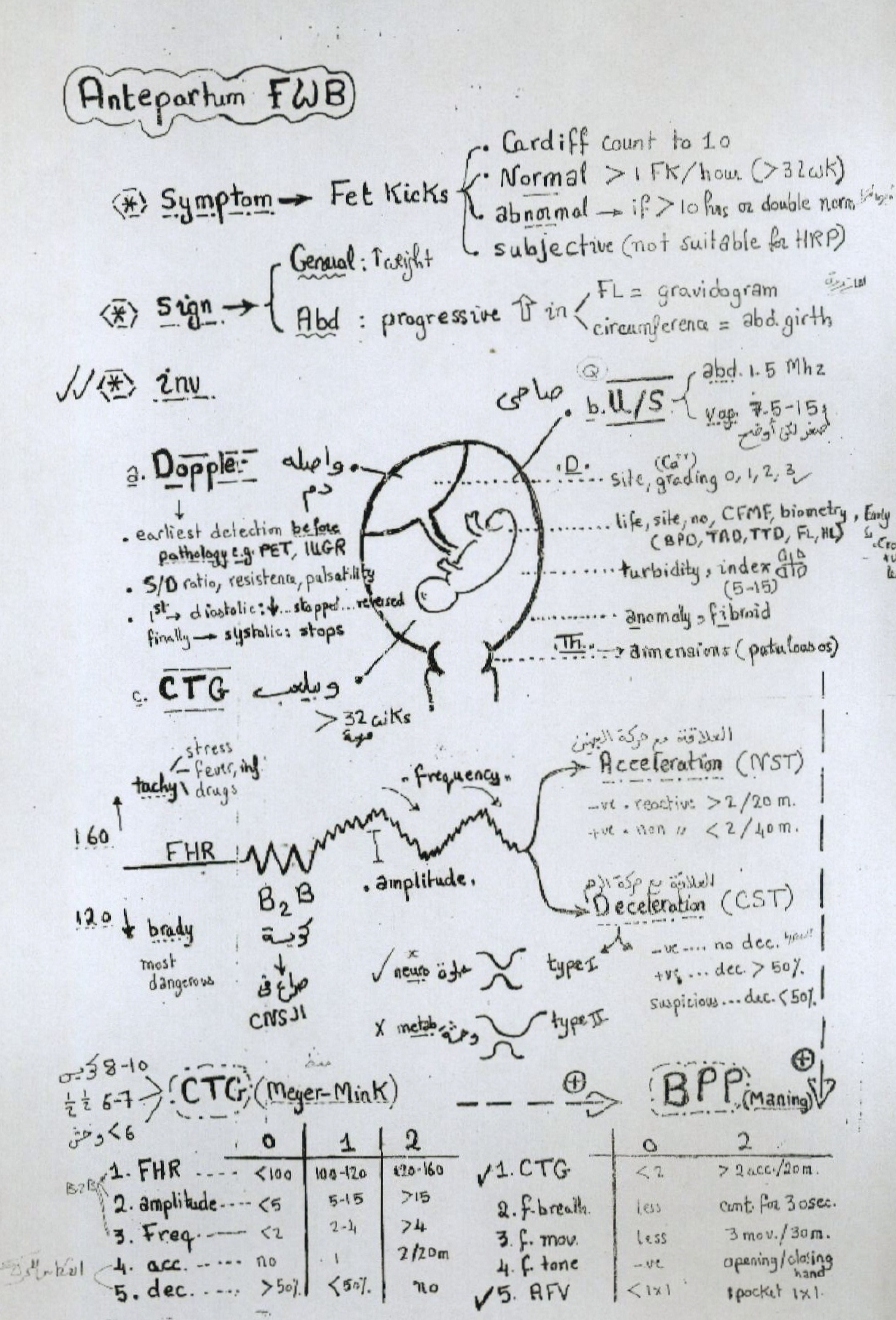




Diagnosis
1st trim.
① Symptoms
. Amenorrhea (not a sure sign)
. Morning sickness
. frequency of mict.
. Breast symptoms
. Appetite changes
. Mood changes
② Signs
. Breast signs
. Genital signs
- Jaque Mier
- Chadwick
- Goodell
- uterus
6-12 wk
Palmer contract.
Hegar sign
③ Investigations
. Preg. test
- Latex 500
- Elisa 50
- RIA 5
. U/S
- TV → 5
- TA → 7
- Sonicaid → 10
GIT
elevated
Mood
depression
CNS
Sleep
over
insomnia
Skin
Endocr. glands
1] Pituitary
↑ size (esp. ant.)
↑ prolactin ↓ FSH LH
.longing (picka) الوحم
.↑ salivation 1.
.morning sickness
2] Thyroid
.slight enlargement (↑TSH)
.↑ thyroid hormones (but free level remains free) as TBG ↑
3] Parathyroid
↑ parathormone to ↑ Ca++ abs.
Breast
.1st weeks → tender, tingling
.2nd m. - 1ry areola pigment. - Montgomery tubercles
.3rd m. → Colostrum
.late months → 2ry areola
Heart burn 2.
- cholestasis
- ↑ globulins 3.
↓ acidity
delayed emptying 4.
4] Supra-renal
↑ free & bound corticosteroids
Kidney
(↑ size 1-1.5 cm)
GFR ↑ ← RBF ↑
↑ clearance creat. urea BUN ↓ plasma level
↓ renal threshold glucose a.a. H2O sol. vit.
Rt
ureter
- dilated
- pyelonephritis
Bladder
- Displaced up
- Frequency of mit. 1st trim. last month
- SUI ?!
5. constipation & piles
1] chloasma gravidarum
→ E may have MSH like activity
→ Chorionic MSH
→ ↑ placental & adrenal steroids
Resp. (d.t. progest.)
dyspnea → Pressure effect
↑ min. O2 uptake
min resp volume
tidal volume
Heart
↑ C.O.P 30-50% (SV x HR)
displaced 4th 5th
Sounds → split of 1st, S3, soft systolic
blood
.Pressure ↓ in 2nd trimester
.Volume ↑ 40-50% (30-34 wk)
.RBCs ↑ 18-30% (phys. anemia)
.WBCs ↑ slightly
.Coag. ↑ 7-10 ↓ fibrinolysis, mild ↓ platelet
.ESR ↑
2] striae gravidarum
3] linea nigra
4] Divarication of recti
no ov.
CL of preg. sec. E, P, Relaxin (till 10-12 wks)
functional cyst may form
Preg. luteoma
Goodell
Chadwick
Jacque Meir
.weight 50gm → 1 Kg
.Shape Pear shape
.Parts - LUS (Ring) - LUS (Hegar sign)
.Cont. - Palmer - Br. Hicks
Diagnosis
2nd trim.
① Symptoms
. Amenorrhea
. ↑ Br. symptoms
. Quickening PG: 18-20 MG: 16-18
. Progressive abd enlargement
② Signs
. Breast
. Genital
Braxton Hick's
uterine soufle
. Fetal
- Ballottement
internal 16-28
external >24
Sure signs of preg. + U/S
- Palpation
- inspection or palpation of movement
- Auscultation of FHS or umbilical soufle (funic soufle)
③ Inv.
.Body weight :- 9-12.5 Kg
.Proteins :- +ve N2 balance (1 Kg protein)
.CHO :- diabetogenic
.lipid :- increased lipids cholesterol
.vitamins :- ↑ fat sol. ↓ H2O sol.
.minerals :- ↓ serum iron
الأكل * caloric intake 2200 ± 300
النوم * Rest 8, 2 → ↓ A-C compression, ↑ pl. flow
بالمعقول * Exercise * Clothing: loose → lordosis
* Travel → long flights } DVT
يا ريت * Bathing → tub bath

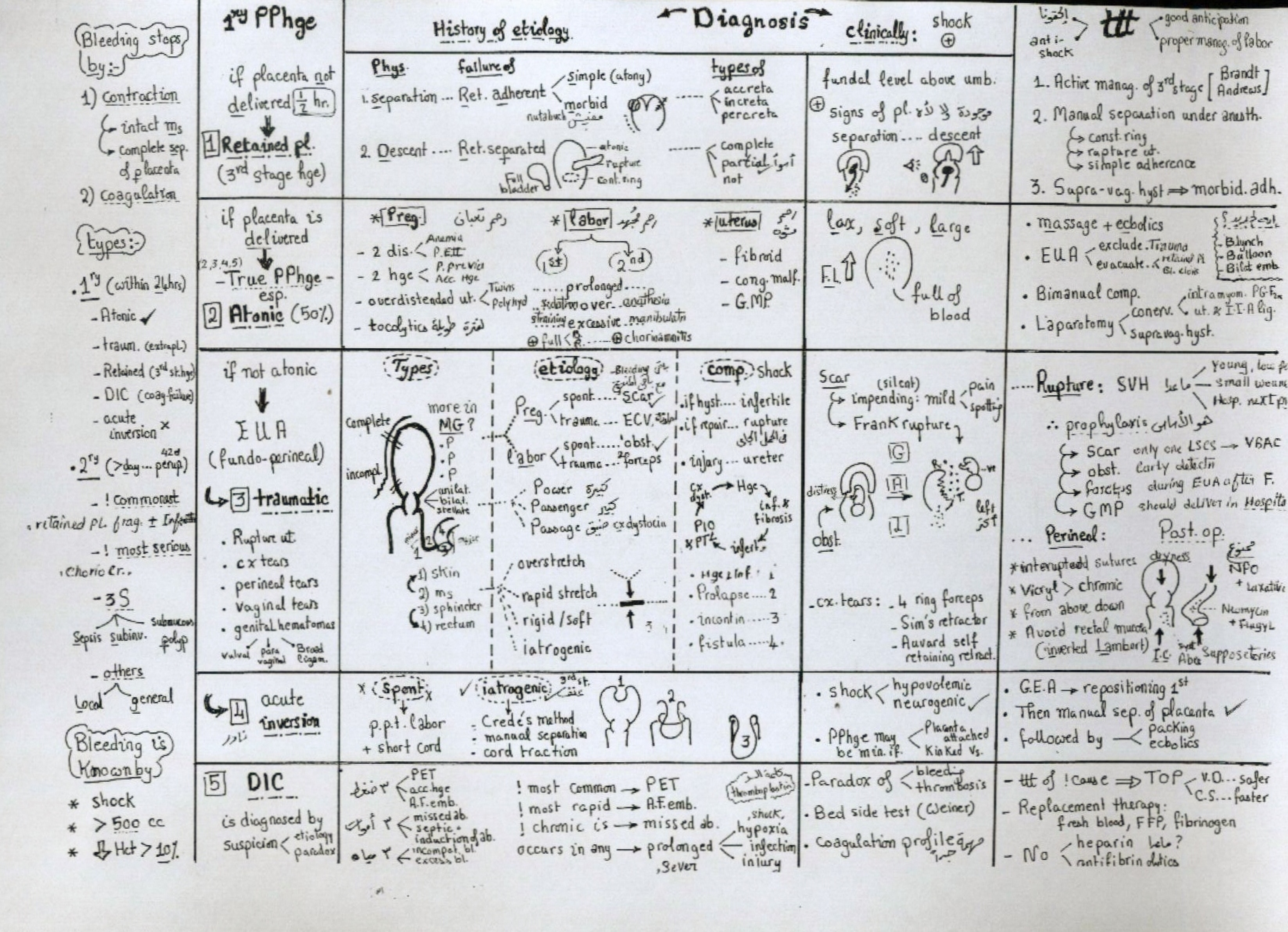


1. Patho physiology
30 قوة
5
0.5
x 6
x 20
10 ضعف
11th
max.at. 30-34
40th
Bleeding
Stretch
gradual → reccurrent
Physiolog. → causeless
LUS → painless
near ! vag. → fresh bl.
الشكوى
2. Etiology
إيه اللي خلاني أعمل عليه فاليوم ٧ وما منش فتح ؟ حبة فول شيء كبيرة
villi
decidua
Z. pell.
1 2 3 4
lateralis marginalis centralis
minor 90% major 10%
3. C/P
G: anemia
A: palpation
FL ..... عادي
FG.
UG
soft
PG ..... عالي
auscultation عايش
L: ممنوع قاطعة
4. Inv. U/S → detect exact site & follow up
FWB U/S Doppler CTG, BPP
تتحسن بـ steroids
تكتشف بـ amniocentesis
5. Comp.
M
Preg. ..... PTL
Parturition
1st ..... prolonged, PROM
2nd ..... malpresent. → obst.
3rd ..... PPhge - atonic - Retained "accreta" - traumatic
Puerperium 3S
• sepsis • subinvolution • secondary PPhge
حروف الـ P.
F → C.F.M.F, IUGR, PTL, IUFD
6. ttt
Hospitilization
Conserv. غالباً
TOP
المرض ..... mild bl.
الأم ..... not in labor
الجنين ..... no distress
لو اتعكست
A Anti-shock
B Delivery
V.D. mild bleeding minor degree
1st ..... cont. monitor - M & F
2nd ..... prolonged, obst.
3rd ..... guard against PPhge
غالباً C.S. severe bleeding major degree
• not fit / failed induction
• F/M distress
• Associated obst. indic.
C Care of ... mother, newborn
1. Patho physiology
strong
tough
E.C.V.
trauma
hematoma
Rupture uterus
Couvelaire uterus
shock
DIC
A.F. embolism
↑ IUP.
الشكوى
P.E.T. 1
acc. hge 2
D.IC 3
الثلاثية الشهيرة
2. Etiology
إيه اللي خلا الـ vessel يتقطع ؟ أشهر حاجة PET. 50%
concealed revealed mixed
10% 90%
3. C/P
G: shock
A: palpation
FL ..... عالي
FG
UG
rigid
PG ..... عادي well engaged
auscult. تعبان ← ميت
L: ممنوع قاطعة إلا بعد
4. Inv. U/S → to exclude p. previa
proteinuria (PET), FDPs (DIC)
5. Comp.
once occured
automatic ext.
شاكل severe
M
Hematoma 2
Shock ..... APhge
DIC
PPhge • atonic • traumatic • DIC
↑ IUPr
Couvelaire & rupture
A.F. emb.
F → IUGR, PTL, IUFD
6. ttt
= chr. abruption نادرة
Conserv. x
TOP غالباً
المرض ..... severe bl.
الأم ..... in labor
الجنين ..... distressed
A Antishock
B Delivery
غالباً V.D. ..... ↑ IUPR + well engaged head = easy delivery
كلمة الـ ARom
C.S. ..... if F/M distress
بس لازم تصلح الـ DIC
C Care of ... mother, newborn
PET DIC
ABGAR score



	0	1	2
1. FHR	<100	100-120	120-160
2. amplitude	<5	5-15	>15
3. Freq.	<2	2-4	>4
4. acc.	no	1	2/20m
5. dec.	>50%	<50%	no

	0	2
✓ 1. CTG	< 2	> 2 acc./20 m.
2. f. breath.	less	cont. for 30 sec.
3. f. mov.	less	3 mov./30 m.
4. f. tone	-ve	opening/closing hand
✓ 5. AFV	< 1x1	1 pocket 1x1



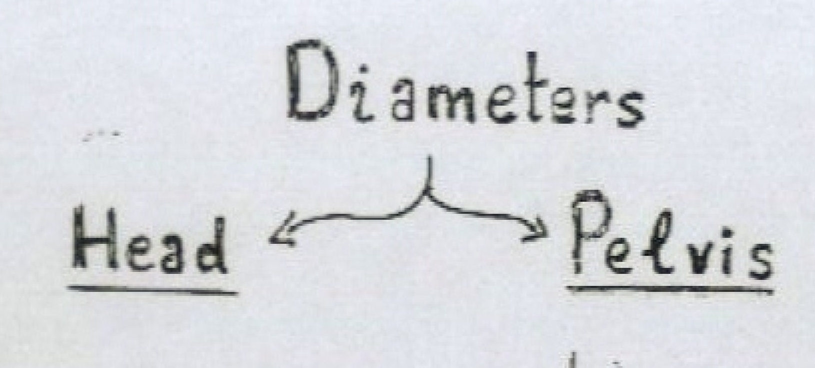
Bleeding stops by:-
1) contraction
- intact ms
- complete sep. of placenta
2) coagulation

types:-
- 1ry (within 24hrs)
  - Atonic ✓
  - traum. (extrapl.)
  - Retained (3rd st.hge)
  - DIC (coag. failure)
  - acute inversion ×
- 2ry (>day ... 42d perup)
  - ! commonest
  - retained PL. frag. ± Infection
  - ! most serious
  - Chorio Cr.
  - 3S: Sepsis, subinv., submucous polyp
  - others: Local, general

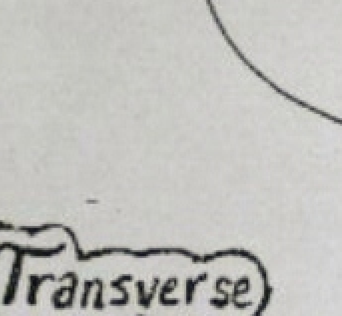
Bleeding is known by
* shock
* > 500 cc
* ⇩ Hct > 10%

1ry PPhge	History of etiology	Diagnosis — clinically: shock ⊕	ttt (anti-shock; good anticipation; proper manag. of labor)
if placenta not delivered ½ hr. → 1 Retained pl. (3rd stage hge)	Phys. / failure of / types of: 1. separation ... Ret. adherent < simple (atony), morbid (accreta, increta, percreta). 2. Descent ... Ret. separated (atonic, rupture, cont. ring, full bladder) ... complete, partial, not	fundal level above umb. ⊕ signs of pl. separation ... descent	1. Active manag. of 3rd stage [Brandt Andrews]. 2. Manual separation under anesth. → const. ring, rupture ut., simple adherence. 3. Supra-vag. hyst ⇒ morbid. adh.
if placenta is delivered → (2,3,4,5) True PPhge esp. 2 Atonic (50%)	*Preg.: 2 dis. < Anemia, P.E.T; 2 hge < P. previa, Acc. Hge; overdistended ut. < Twins, Polyhyd; tocolytics. *labor: 1st, 2nd ... prolonged ... sedation over anesthesia, straining excessive manipulation, ⊕ full bladder ... ⊕ chorioamnitis. *uterus: fibroid, cong. malf., G.M.P.	lax, soft, large; F.L. ⇧; full of blood	• massage + ecbolics • EUA < exclude Trauma, evacuate retained pl. / Bl. clots (B-lynch, Balloon, Bilat emb.) • Bimanual comp. • Laparotomy < conserv. (intramyom. PGF2α, ut. & I.I.A lig.), Supra vag. hyst.
if not atonic → EUA (fundo-perineal) → 3 traumatic: • Rupture ut • cx tears • perineal tears • Vaginal tears • genital hematomas (Vulval, para vaginal, Broad ligam.)	Types: complete, incompl.; more in MG? P P P; unilat., bilat., stellate; 1) skin 2) ms 3) sphincter 4) rectum. etiology: Preg. spont ... scar; trauma ... ECV; labor spont ... obst.; trauma ... forceps; Power, Passenger, Passage cx dystocia; overstretch, rapid stretch, rigid/soft, iatrogenic. comp. Shock: if hyst ... infertile; if repair ... rupture; injury ... ureter; cx dyst. → Hge → inf. & fibrosis → infert. → PTL → PIO; Hge & Inf. 1, Prolapse 2, incontin. 3, fistula 4	Scar (silent) → impending: mild pain, spotting → Frank rupture; obst.; G A I; cx. tears: 4 ring forceps, Sim's retractor, Auvard self retaining retract.	... Rupture: SVH (Young, low parity, small wound, Hosp. next p) ∴ prophylaxis: Scar only one LSCS → VBAC; obst. early detection; forceps during EUA after F.; GMP should deliver in Hospital. ... Perineal: *interrupted sutures *Vicryl > chromic *from above down *Avoid rectal mucosa (inverted Lambert). Post. op.: dryness, NPO + laxative, Neomycin + Flagyl, Suppositories, I.C., Abs
4 acute inversion	× Spont × → p.p.t. labor + short cord; ✓ iatrogenic (3rd st.): Crede's method, manual separation, cord traction; 1, 2, 3	• shock < hypovolemic, neurogenic ✓ • PPhge may be min. if Placenta attached, Kinked Vs.	• G.E.A → repositioning 1st • Then manual sep. of placenta ✓ • followed by < packing, ecbolics
5 DIC is diagnosed by suspicion < etiology, paradox	PET, acc. hge, A.F. emb.; missed ab., septic, induction of ab.; incompat. bl., excess bl. ! most common → PET; ! most rapid → A.F. emb.; ! chronic is → missed ab.; occurs in any → prolonged, sever shock, hypoxia, infection, injury (thromboplastin)	Paradox of < bleeding, thrombosis; Bed side test (Weiner); Coagulation profile	– ttt of ! cause ⇒ TOP < V.D ... safer, C.S ... faster; – Replacement therapy: fresh blood, FFP, fibrinogen; – No < heparin, antifibrinolytics

Diameters

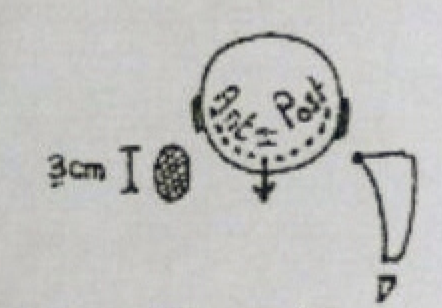


Head

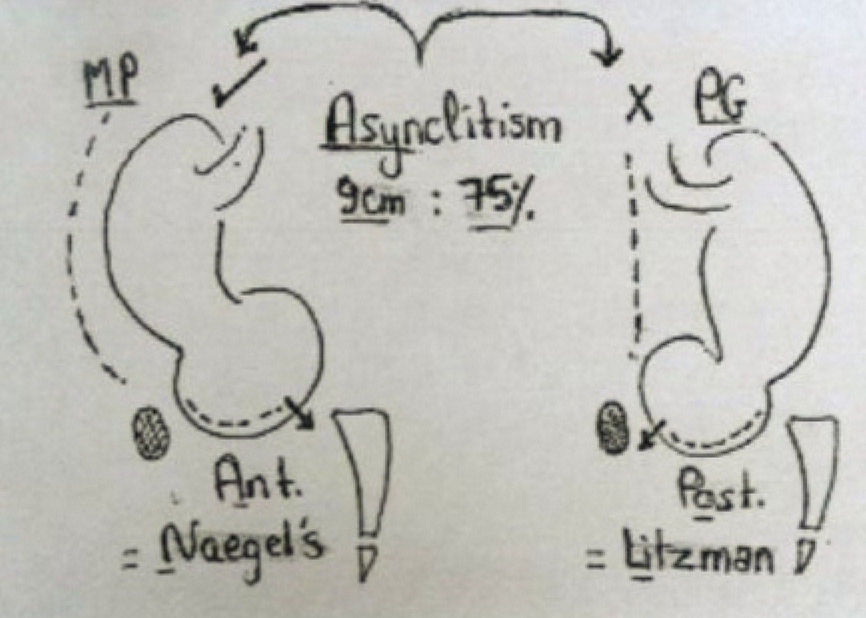


Transverse

Biparietal 9.5
Bitemporal 8.5
Bi mastoid 7.5

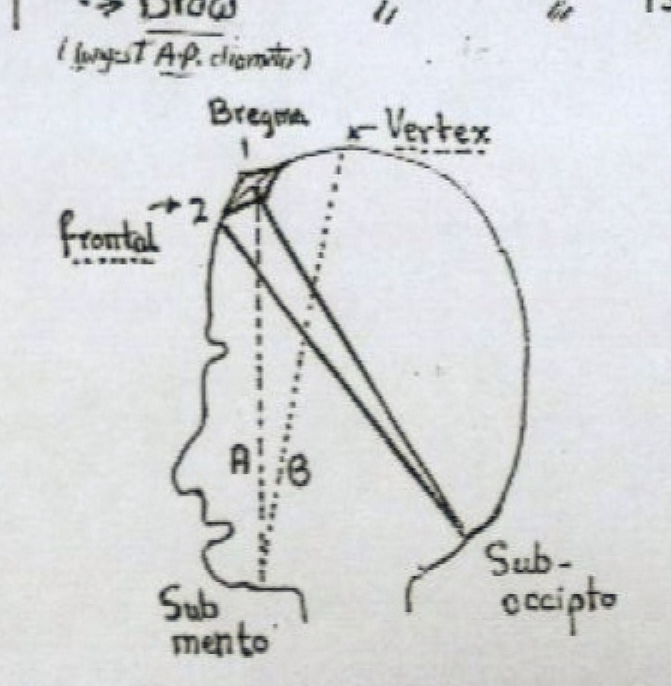


9.5cm: Synclism: 25%



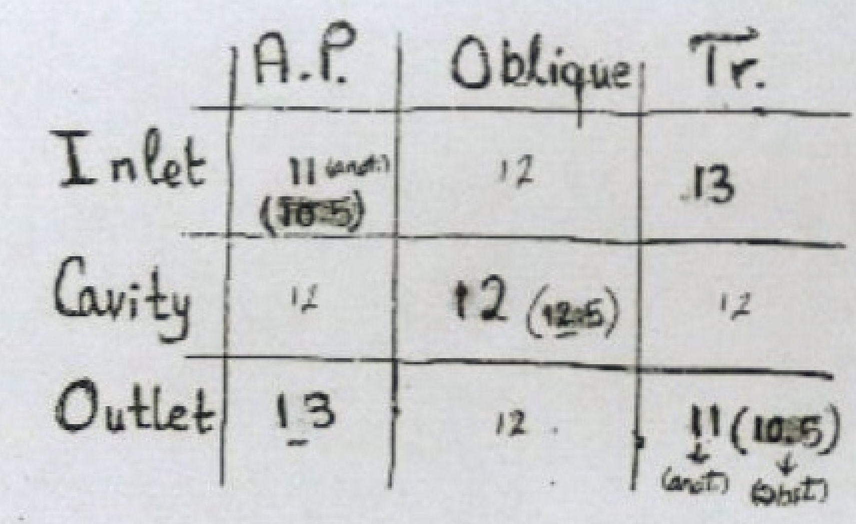
Longitudinal

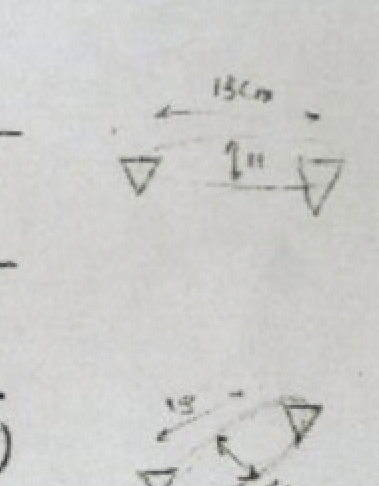
1.	flexion O.A.	fully flexed	Sub occipito bregmatic	9.5
2.		not	" " (frontal)	10
3.	O.P.		" "	11.5
A.	extension Face	fully extended	Sub Mento bregmatic	9.5
B.		not	" " (vertical)	11.5
C.	Brow (longest A.P. diameter)		" "	13.75

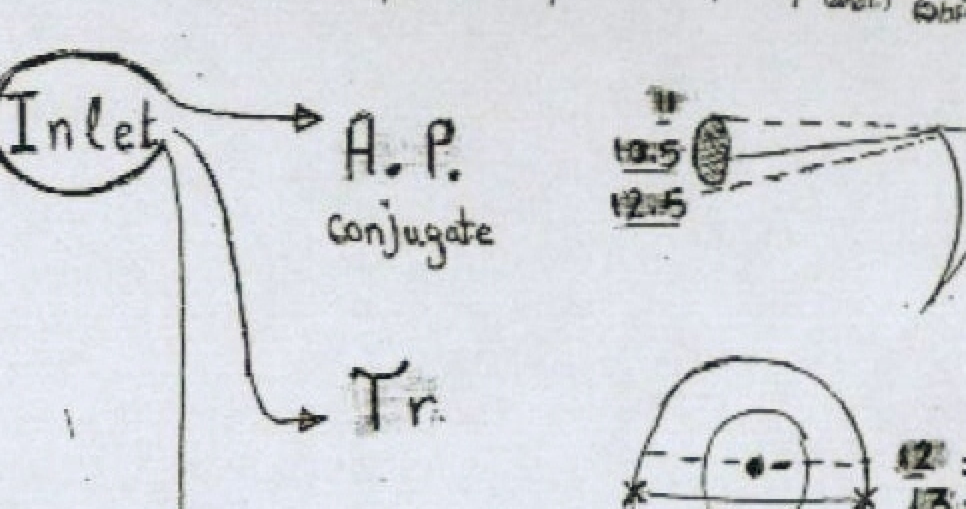


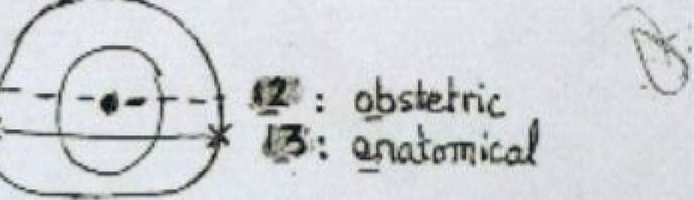
Pelvis

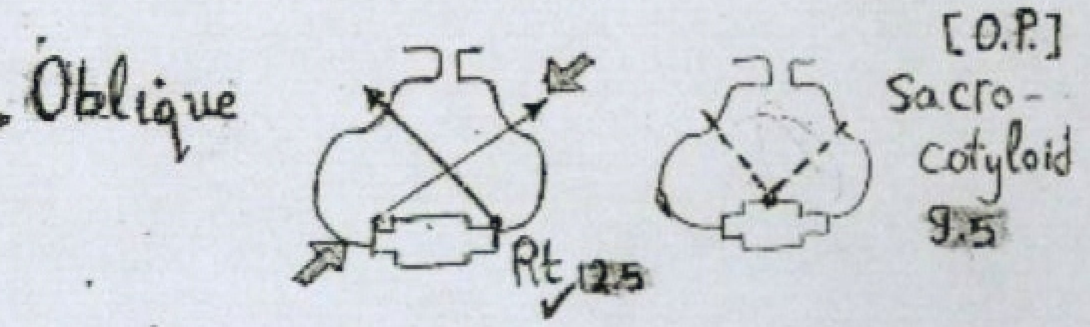
	A.P.	Oblique	Tr.
Inlet	11 (anat) (10.5)	12	13
Cavity	12	12 (12.5)	12
Outlet	13	12	11 (10.5) (anat) (obst)





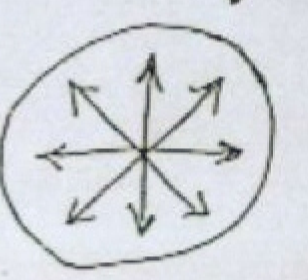






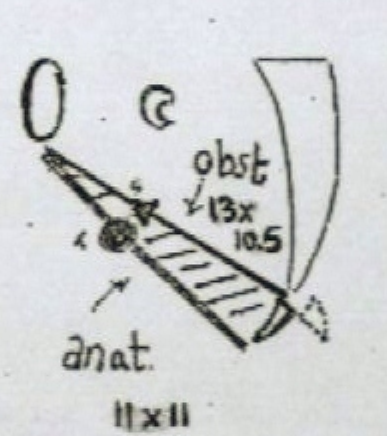


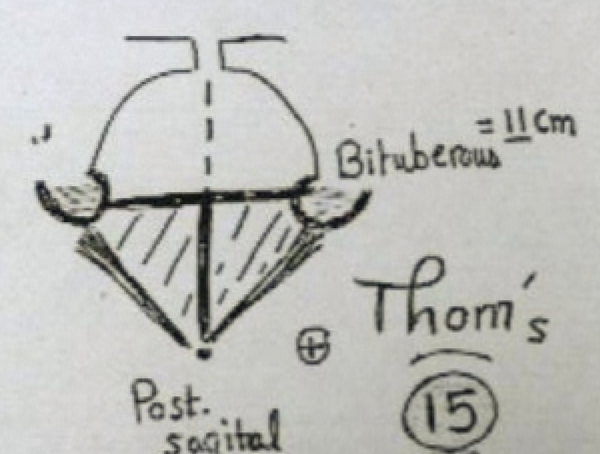
12.5 x 12.5

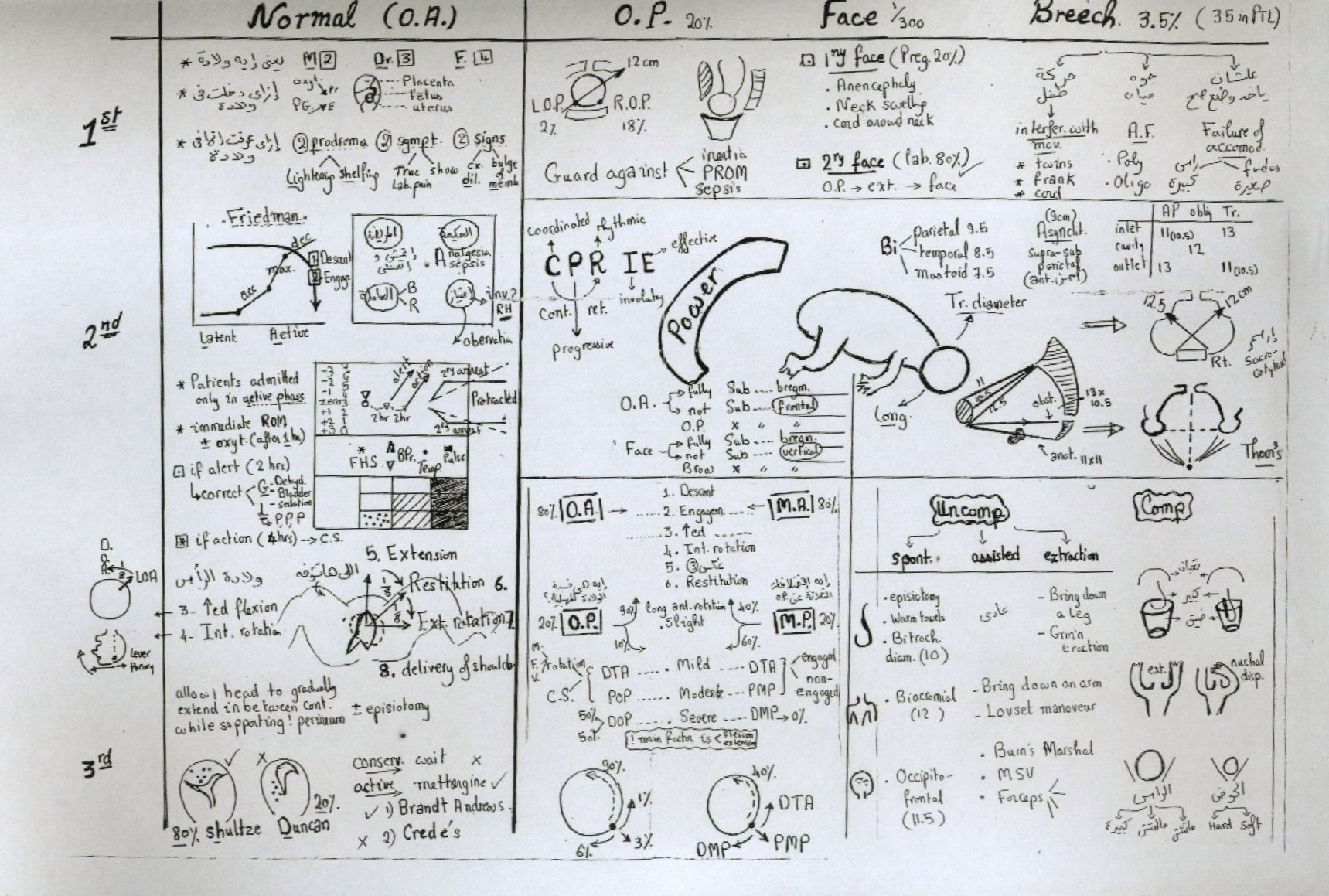


Plane of greatest pelvic dimension

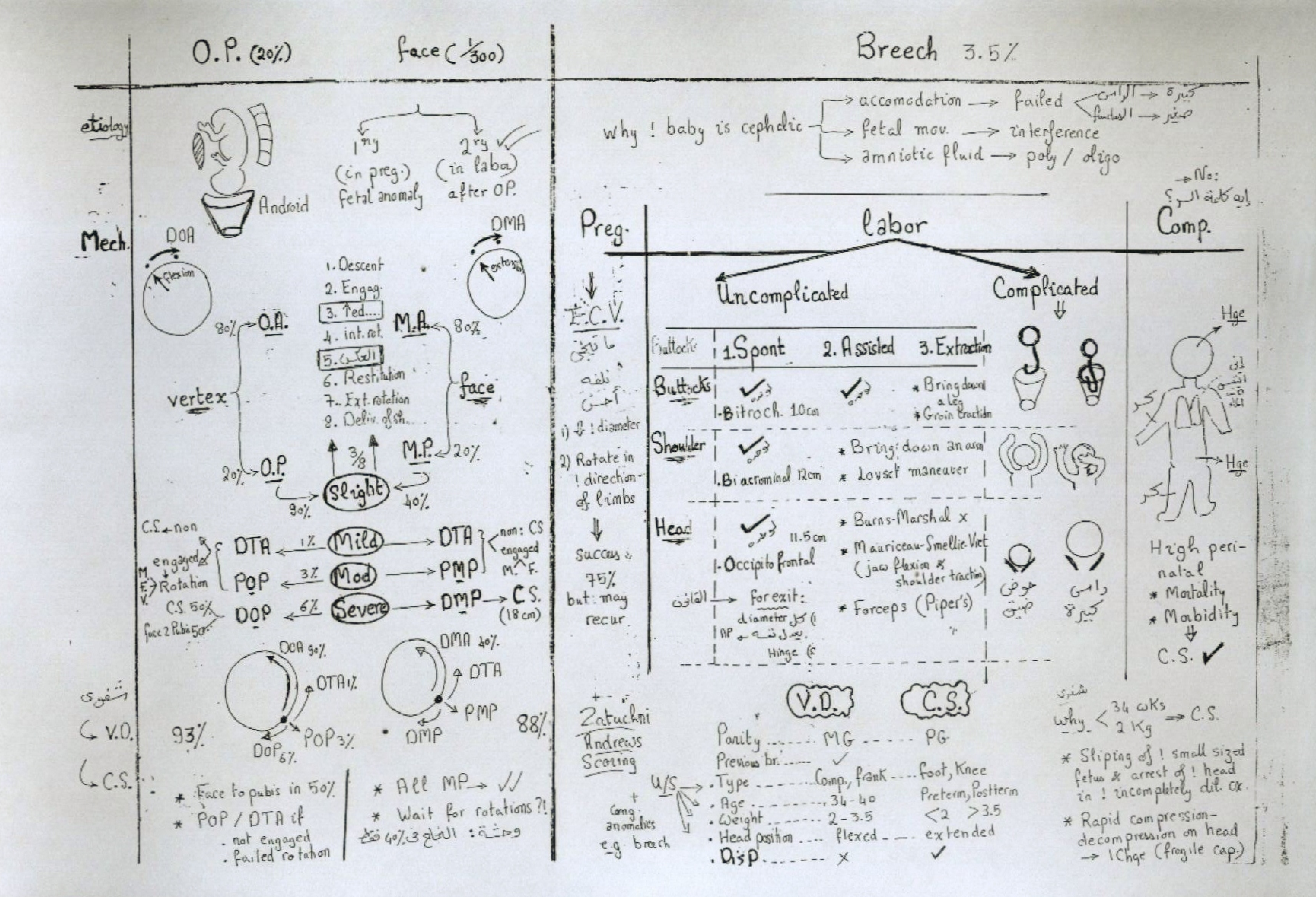




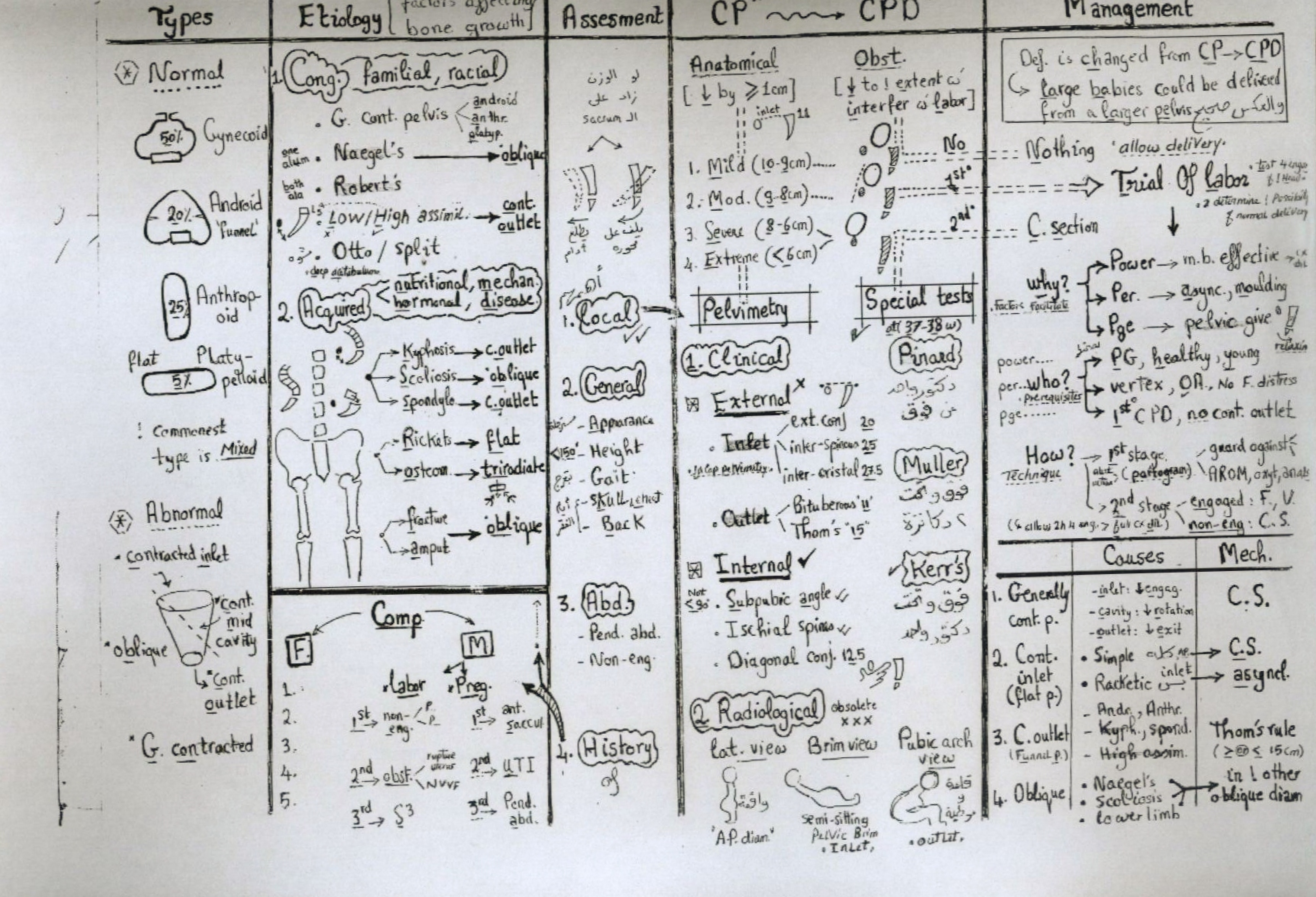




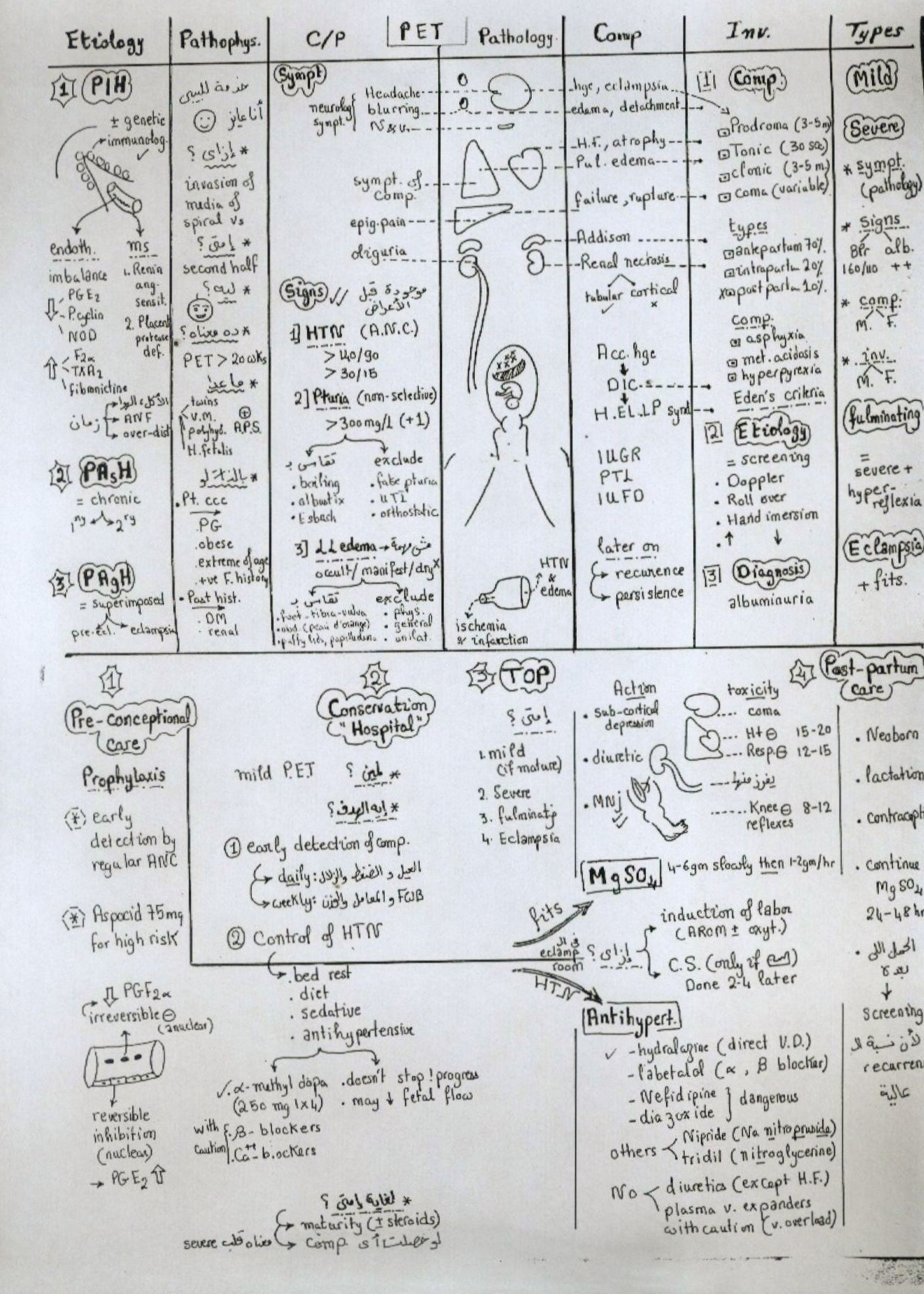
Normal (O.A.)
O.P. 20%
Face 1/300
Breech 3.5% (35 in PTL)
1st
2nd
3rd
M 2
Dr. 3
F. 4
Placenta
fetus
uterus
② prodroma
② sympt.
② signs
Lightening
shelfing
True lab. pain
show
cx. dil.
bulge of memb
12 cm
L.O.P. 2%
R.O.P. 18%
Guard against
inertia
PROM
sepsis
1ry face (Preg. 20%)
. Anencephaly
. Neck swelling
. cord around neck
2ry face (lab. 80%)
O.P. → ext. → face
interfer. with mov.
* twins
* frank
* cord
A.F.
. Poly
. Oligo
Failure of accomod.
Friedman
dec
max.
acc
Latent
Active
1 Descent
2 Engag.
Analgesia
sepsis
B
R
inv.?
RH
oberveation
coordinated
rhythmic
effective
CPR IE
Cont.
ret.
involuntary
progressive
Power
Bi
parietal 9.5
temporal 8.5
mastoid 7.5
(9cm)
Asynclit.
Supra-sub parietal
AP
oblq.
Tr.
inlet
cavity
outlet
11 (10.5)
13
12
13
11 (10.5)
Tr. diameter
12.5
12 cm
Rt.
Sacro-cotyloid
* Patients admitted only in active phase
* immediate ROM ± oxyt. (after 1 hr)
if alert (2 hrs)
correct
Dehyd.
Bladder
sedation
P.P.P
if action (4 hrs) --> C.S.
alert
action
2hr
2hr
2ry arrest
2ry arrest
Protracted
FHS
BP.
Temp
Pulse
O.A.
fully
not
Sub .... bregm.
Sub .... frontal
O.P.
Face
Brow
bregm.
vertical
Long.
obst.
13 x 10.5
anat. 11 x 11
Thoms
5. Extension
Restitution 6.
Ext. rotation 7
8. delivery of shoulder
LOA
3- ↑ed flexion
4- Int. rotation
lever theory
allow head to gradually extend in between cont. while supporting perineum
± episiotomy
80% O.A.
1. Descent
2. Engagem.
3. ↑ed
4. Int. rotation
5.
6. Restitution
M.A. 80%
20% O.P.
Long ant. rotation
. Slight
M.P. 20%
90%
10%
40%
60%
DTA .... Mild .... DTA
POP .... Moderate .... PMP
DOP .... Severe .... DMP → 0%
engaged
non-engaged
C.S.
main factor is flexion / extension
Uncomp
Comp
spont.
assisted
extraction
. episiotomy
. Warm towels
. Bitroch. diam. (10)
- Bring down a Leg
- Groin traction
. Biacromial (12)
- Bring down an arm
- Louvset manoeuver
. Occipito-frontal (11.5)
. Burn's Marshal
. MSV
. Forceps
ext.
nuchal disp.
conserv. wait ×
active methergine ✓
✓ 1) Brandt Andrews
× 2) Crede's
80% Shultze
Duncan 20%
90%
1%
6%
3%
40%
DTA
DMP
PMP
Hard
Soft



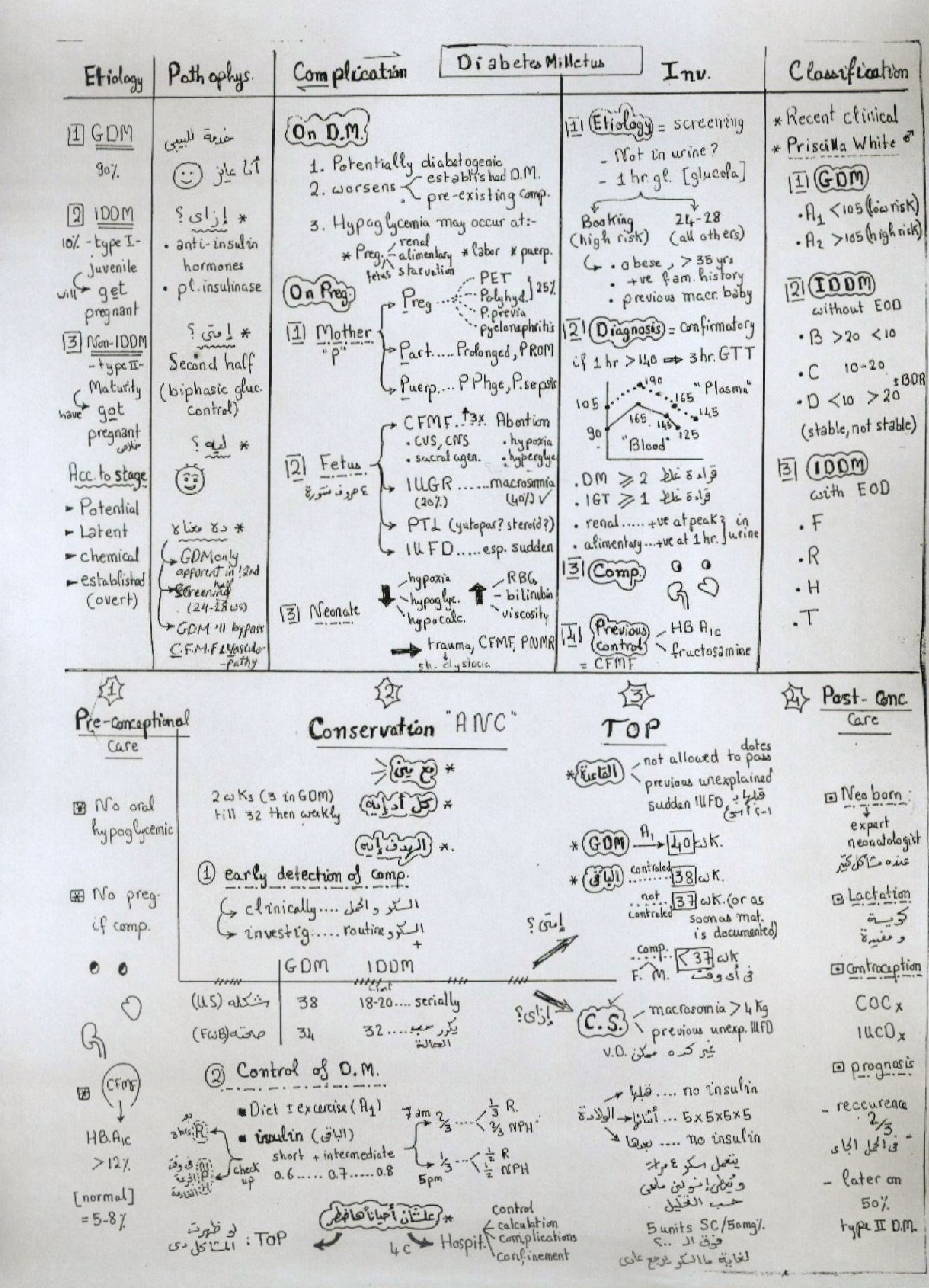
O.P. (20%)
face (1/300)
Breech 3.5%
etiology
Android
1ry (in preg.) fetal anomaly
2ry (in laba) after OP.
why ! baby is cephalic
accomodation → failed
fetal mov. → interference
amniotic fluid → poly / oligo
→ No:
ايه كلمة السر؟
Mech.
DOA
flexion
DMA
extension
1. Descent
2. Engag.
3. Fed...
4. int. rot.
5. العكس
6. Restitution
7. Ext. rotation
8. Deliv. of sh.
80% → O.A.
M.A. 80%
vertex
face
20% → O.P.
M.P. 20%
3/8
Slight
90%
40%
C.S. ← non engaged
M. F. V. → Rotation
C.S. 50%
face 2 Pubis 50%
DTA ← 1% Mild → DTA
POP ← 3% Mod → PMP
DOP ← 6% Severe → DMP → C.S. (18 cm)
non: CS engaged M.^F.
DOA 90%
OTA 1%
POP 3%
DOP 6%
93%
DMA 40%
DTA
PMP
DMP
88%
شفوى
V.D.
C.S.
* Face to pubis in 50%
* POP / DTA if
. not engaged
. failed rotation
* All MP → √√
* Wait for rotations ?!
Preg.
E.C.V.
ما تيجي نلفه أحسن
i) ↓ ! diameter
2) Rotate in ! direction of limbs
success 75%
but: may recur
labor
Uncomplicated
Complicated
Comp.
Buttocks
1. Spont
2. Assisted
3. Extraction
Buttocks
Bitroch. 10cm
* Bring down a leg
* Groin traction
Shoulder
Biacromial 12cm
* Bring down an arm
* Lovset maneuver
Head
11.5 cm
Occipito frontal
* Burns-Marshal x
* Mauriceau-Smellie-Viet (jaw flexion & shoulder traction)
* Forceps (Piper's)
القانون → for exit:
Hinge
حوض ضيق
راس كبيرة
Hge
Hge
High perinatal
* Mortality
* Morbidity
C.S. ✓
Zatuchni Andrews Scoring
U/S
+ Cong. anomalies e.g. breech
V.D.
C.S.
Parity ...... MG ...... PG
Previous br. ...... ✓
. Type ...... Comp., frank ...... foot, Knee
. Age ...... 34-40 ...... Preterm, Postterm
. Weight ...... 2-3.5 ...... <2 >3.5
. Head position ...... flexed ...... extended
. Disp ...... x ...... ✓
why < 34 wks, 2 Kg ⇒ C.S.
* Sliping of ! small sized fetus & arrest of ! head in ! incompletely dil. cx.
* Rapid compression-decompression on head → ICHge (fragile cap.)



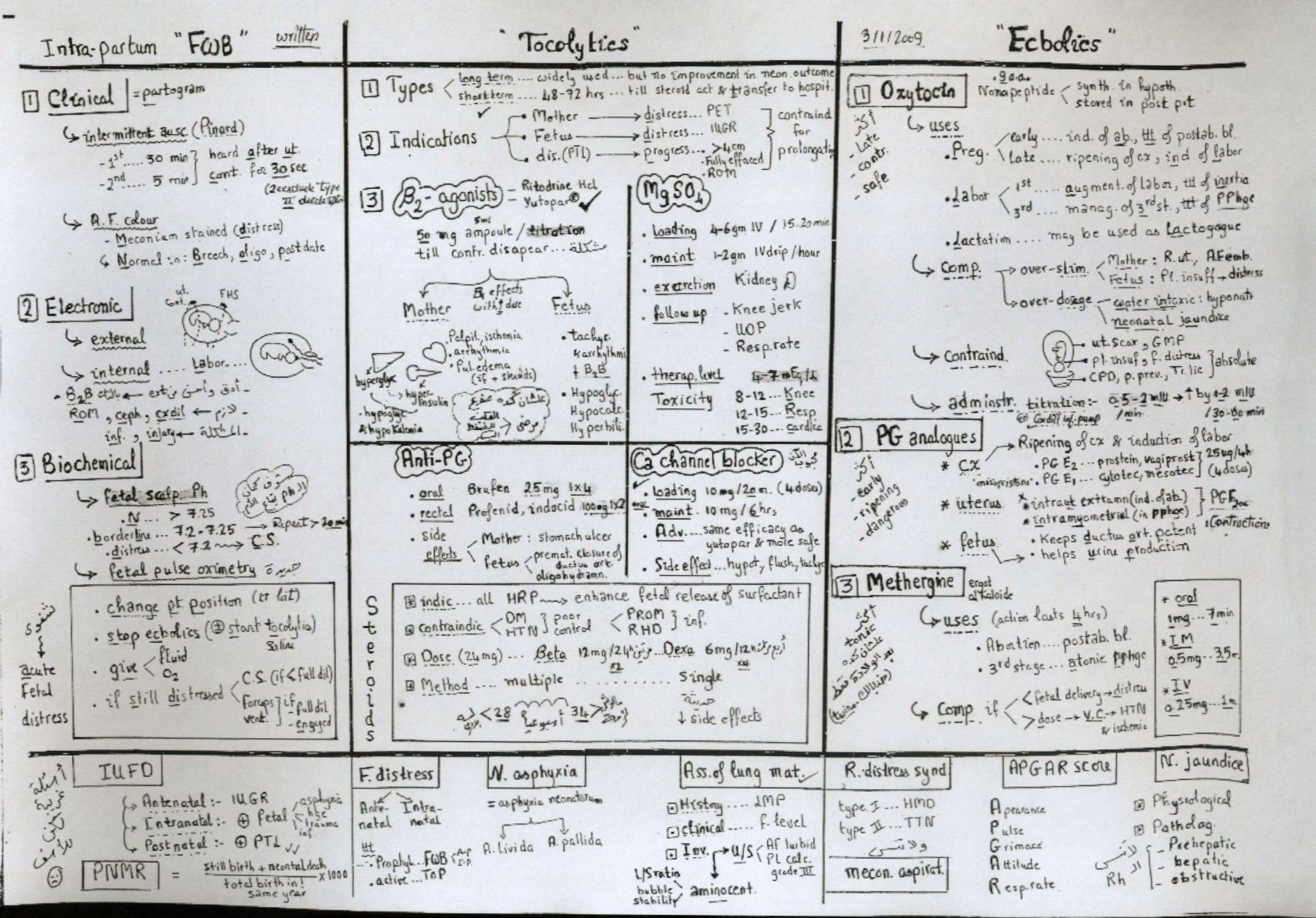
Types
Etiology [factors affecting bone growth]
Assesment
CP ⟶ CPD
Management
Normal
50% Gynecoid
20% Android 'Funnel'
25% Anthropoid
flat 5% Platypelloid
! Commonest type is Mixed
Abnormal
• contracted inlet
cont. mid cavity
• oblique
cont. outlet
• G. contracted
1. Cong. familial, racial
• G. Cont. pelvis < android, anthr., platyp.
one ala • Naegel's → oblique
both ala • Robert's
L5 Low/High assimil. → cont. outlet
• Otto / split
• deep acetabulum
2. Acquired < nutritional, mechan., hormonal, disease
Kyphosis → c. outlet
Scoliosis → oblique
Spondylo → c. outlet
Rickets → flat
osteom → triradiate
fracture → oblique
amput
Comp
F
M
1.
2.
3.
4.
5.
Labor
Preg.
1st → non-eng. < P., P.
1st → ant. saccul
2nd → obst. < rupture uterus, NVVF
2nd → UTI
3rd → S3
3rd → Pend. abd.
لو الوزن زاد على ال sacrum
يطلع لقدام
يلف على محوره
1. Local
2. General
- Appearance
<150' - Height
- Gait
- Skull
- Back
3. Abd.
- Pend. abd.
- Non-eng.
4. History
Anatomical [↓ by ≥ 1cm]
Obst. [↓ to ! extent c interfer c labor]
inlet 11
1. Mild (10-9cm)
2. Mod. (9-8cm)
3. Severe (8-6cm)
4. Extreme (<6cm)
No
1st
2nd
Pelvimetry
Special tests at (37-38 w)
1. Clinical
External
• Inlet: ext. conj 20, inter-spinous 25, inter-cristal 27.5
• Outlet: Bituberous 11, Thom's 15
Internal
Not <90 • Subpubic angle
• Ischial spines
• Diagonal conj. 12.5
2. Radiological obsolete xxx
lat. view
Brim view
Pubic arch view
'A.P. diam'
Semi-sitting Pelvic Brim • Inlet
• outlet
Pinard
دكتور واحد من فوق
Muller
فوق و تحت
دكاترة 2
Kerr's
فوق و تحت
دكتور واحد
Def. is changed from CP → CPD
↳ large babies could be delivered from a larger pelvis & والعكس صحيح
Nothing 'allow delivery'
Trial Of labor
test 4 engag. & ! Head
2 determine ! Possibility of normal delivery
C. section
why? Factors facilitate
Power → m.b. effective
Per. → async., moulding
Pge → pelvic give relaxin
power....
per... who?
pge...... Prerequisites
PG, healthy, young
vertex, OA, No F. distress
1st CPD, no cont. outlet
How? Technique
1st stage (partogram)
guard against ! AROM, oxyt, anals
2nd stage
engaged: F, V.
non-eng: C.S.
(& allow 2h 4 eng. > full cx dil.)
Causes
Mech.
1. Generally cont. p.
-inlet: ↓ engag.
-cavity: ↓ rotation
-outlet: ↓ exit
C.S.
2. Cont. inlet (flat p.)
• Simple
• Racketic
inlet
→ C.S.
→ asyncl.
3. C. outlet (Funnel p.)
- Andr., Anthr.
- Kyph., spond.
- High assim.
Thom's rule (≥ 15 cm)
4. Oblique
• Naegel's
• Scoliosis
• lower limb
in ! other oblique diam



Etiology
Pathophys.
C/P
PET
Pathology
Comp
Inv.
Types
1 PIH
± genetic
immunolog.
endoth.
ms
imbalance
PGE2
P.cyclin
NOD
F2α
TXA2
fibronictine
1. Renin ang. sensit.
2. Placent. protease def.
AVF
over-dist
زمان
2 PAsH
= chronic
1ry → 2ry
3 PAgH
= superimposed
pre-ecl.
eclampsia
خدعة للبيبي
أنا كدا؟
* إزاي؟
invasion of media of spiral vs
* إمتى؟
second half
* ليه؟
* مين عنده؟
PET > 20 wks
* ما عدا
twins
V.M.
polyhyd.
A.P.S.
H.fetalis
* بالإضافة
Pt. ccc
PG
obese
extreme of age
+ve F. history
Past hist.
DM
renal
Sympt
neurolog. sympt.
Headache
blurring
N & V.
sympt. of comp.
epig. pain
oliguria
Signs
موجودة قبل الأعراض
1] HTN (A.N.C.)
> 140/90
> 30/15
2] Pturia (non-selective)
> 300 mg/l (+1)
exclude
boiling
albustix
Esbach
false pturia
UTI
orthostatic
3] LL edema
occult / manifest / dry
exclude
foot - tibia - vulva
abd. (peau d'orange)
puffy lids, papilledema
phys.
general
unilat.
HTN & edema
ischemia & infarction
hge, eclampsia
edema, detachment
H.F., atrophy
Pul. edema
failure, rupture
Addison
Renal necrosis
tubular
cortical
Acc. hge
DIC
H.EL.LP synd.
IUGR
PTL
IUFD
later on
recurrence
persistence
1 Comp.
Prodroma (3-5m)
Tonic (30 sec)
clonic (3-5 m.)
coma (variable)
types
antepartum 70%
intrapartum 20%
postpartum 10%
Comp.
asphyxia
met. acidosis
hyperpyrexia
Eden's criteria
2 Etiology
= screening
Doppler
Roll over
Hand imersion
3 Diagnosis
albuminuria
Mild
Severe
* sympt. (pathology)
* Signs
BP 160/110
alb. ++
* comp.
M.
F.
* inv.
M.
F.
fulminating
= severe + hyper-reflexia
Eclampsia
+ fits.
1 Pre-conceptional care
Prophylaxis
early detection by regular ANC
Aspocid 75 mg for high risk
PGF2α
irreversible (anuclear)
reversible inhibition (nuclear)
PGE2
2 Conservation "Hospital"
mild PET
* ليه؟
* إيه الهدف؟
① early detection of comp.
daily: العيل و الضغط و الزلال
weekly: الأملاح و الدم, FCB
② Control of HTN
bed rest
diet
sedative
antihypertensive
α-methyl dopa (250 mg 1x4)
doesn't stop! progress
may ↓ fetal flow
with caution
β-blockers
Ca++-blockers
* لغاية إمتى؟
maturity (± steroids)
comp.
severe
3 TOP
* إمتى؟
1. mild (if mature)
2. Severe
3. fulminatg
4. Eclampsia
fits
eclamp. room
إزاي؟
induction of labor (AROM ± oxyt.)
C.S. (only if ...)
Done 2-4 later
HTN
Action
sub-cortical depression
diuretic
MNJ
toxicity
coma
Ht 15-20
Resp. 12-15
Knee reflexes 8-12
MgSO4
4-6 gm slowly then 1-2 gm/hr
Antihypert.
hydralazine (direct V.D.)
labetalol (α, β blocker)
Nefidipine
diazoxide
dangerous
others
Nipride (Na nitroprusside)
tridil (nitroglycerine)
No
diuretics (except H.F.)
plasma v. expanders with caution (v. overload)
4 Post-partum care
Neoborn
lactation
contracept.
continue MgSO4 24-48 hr
الحمل اللي بعده
screening
لأن نسبة الـ recurrence عالية



Diabetes Milletus
Etiology
Pathophys.
Complication
Inv.
Classification
1 GDM
90%
2 IDDM
10% - type I -
juvenile
will get pregnant
3 Non-IDDM
- type II -
Maturity
have got pregnant
Acc. to stage
► Potential
► Latent
► chemical
► established (overt)
أنا عايز
* إزاي؟
• anti-insulin hormones
• pl. insulinase
* إمتى؟
Second half
(biphasic gluc. control)
* ليه؟
* دة معناه
GDM only apparent in 2nd half
Screening (24-28 ws)
GDM'll bypass C.F.M.F & vasculopathy
On D.M.
1. Potentially diabetogenic
2. worsens < established D.M. / pre-existing comp.
3. Hypoglycemia may occur at:-
* Preg. < renal / alimentary / fetus starvation
* labor
* puerp.
On Preg.
1 Mother "P"
Preg ... PET, Polyhyd., P. previa, pyelonephritis } 25%
Part. ... Prolonged, PROM
Puerp. ... PPhge, P. sepsis
2 Fetus
CFMF ↑3x Abortion
• CVS, CNS
• sacral agen.
• hypoxia
• hyperglyc.
IUGR ...... macrosomia
(20%)
(40%) ✓
PTL (yutopar? steroid?)
IUFD ..... esp. sudden
3 Neonate
↓ hypoxia, hypoglyc., hypocalc.
↑ RBCs, bilirubin, viscosity
→ trauma, CFMF, PNMR
sh. dystocia
1 Etiology = screening
- Not in urine?
- 1 hr. gl. [glucola]
Booking (high risk)
24-28 (all others)
• obese, > 35 yrs
• +ve fam. history
• previous macr. baby
2 Diagnosis = confirmatory
if 1 hr > 140 ⇒ 3 hr. GTT
105
90
190
165
145
165
145
125
"Plasma"
"Blood"
. DM ≥ 2 قراءة غلط
. IGT ≥ 1 قراءة غلط
• renal ..... +ve at peak
• alimentary ... +ve at 1 hr.
in urine
3 Comp.
4 Previous control = CFMF
HB A1c
fructosamine
* Recent clinical
* Priscilla White
1 GDM
• A1 < 105 (low risk)
• A2 > 105 (high risk)
2 IDDM
without EOD
• B > 20 < 10
• C 10-20
• D < 10 > 20 ± BDR
(stable, not stable)
3 IDDM
with EOD
• F
• R
• H
• T
1 Pre-conceptional Care
No oral hypoglycemic
No preg. if comp.
CFMF
HB.A1c > 12%
[normal] = 5-8%
2 Conservation "ANC"
2 wks (3 in GDM) till 32 then weekly
1 early detection of comp.
clinically .... السكر والحمل
investig. .... routine, السكر
+
GDM
IDDM
(US)
38
18-20 .... serially
(FWB)
34
32
2 Control of D.M.
• Diet ± excercise (A1)
• insulin (الباقي)
short + intermediate
0.6 ..... 0.7 ..... 0.8
check up
7 am 2/3 .... 1/3 R. / 2/3 NPH
5 pm 1/3 .... 1/2 R / 1/2 NPH
4 C → Hospit. < control / calculation / complications / confinement
: TOP
3 TOP
* القاعدة
not allowed to pass dates
previous unexplained sudden IUFD
* GDM → A1 → 40 wK.
* الباقي controled ..... 38 wK.
not controled ..... 37 wK. (or as soon as mat. is documented)
comp. F. M. < 37 wk
إمتى؟
إزاي؟
C.S.
macrosomia > 4 Kg
previous unexp. IUFD
V.D.
..... no insulin
..... 5x5x5x5
..... no insulin
5 units SC/50mg%.
4 Post-Conc. Care
Neo born → expert neonatologist
Lactation
Contraception
COC x
IUCD x
prognosis
- reccurence 2/3
- later on 50% type II D.M.

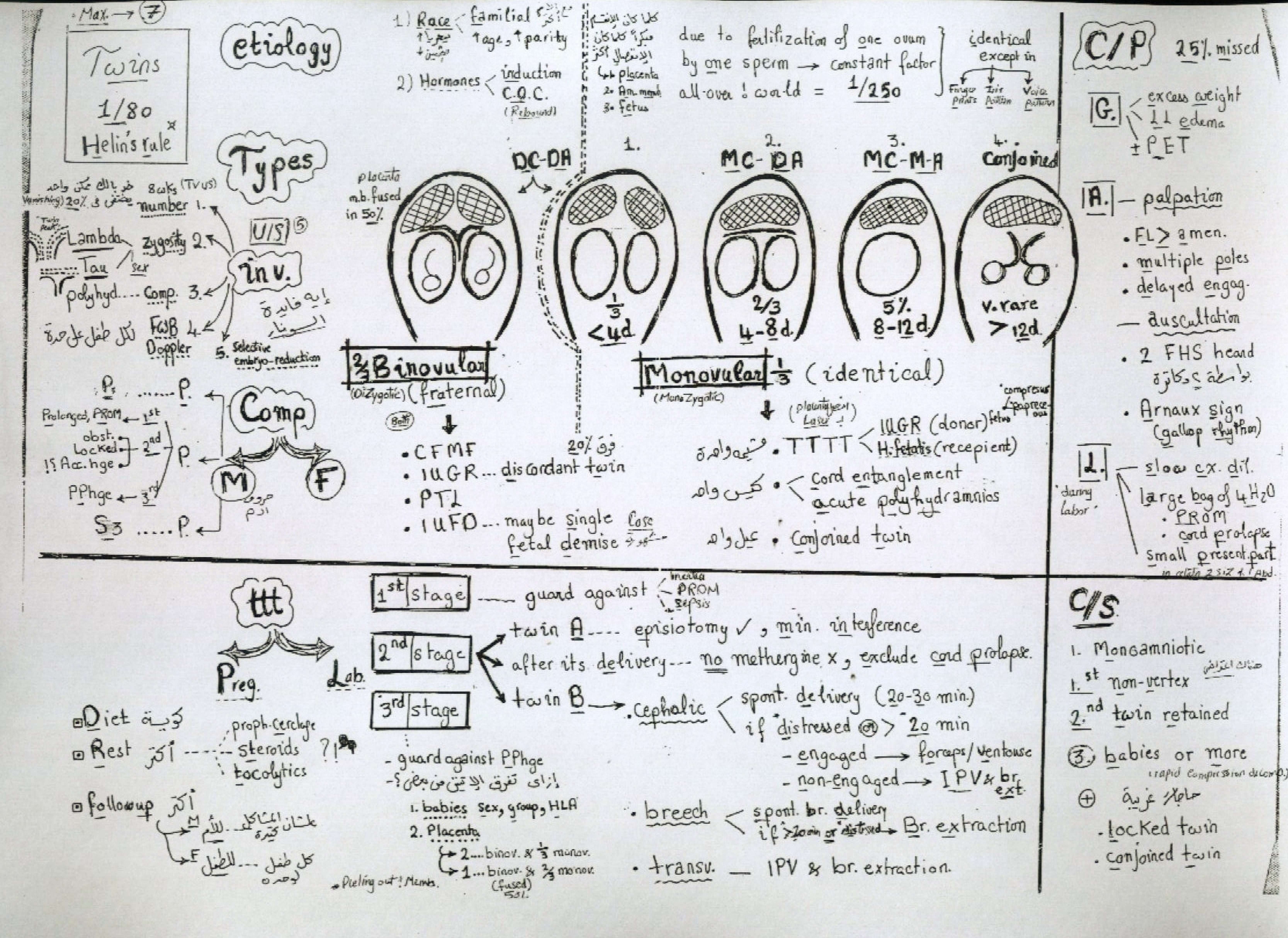


Intra-partum "FWB" written
"Tocolytics"
3/11/2009
"Ecbolics"
1 Clinical = partogram
intermittent ausc (Pinard)
-1st ..... 30 min
-2nd ..... 5 min
heard after ut. cont. for 30 sec
A.F. colour
- Meconium stained (distress)
Normal in: Breech, oligo, postdate
2 Electronic
external
internal .... Labor ....
ROM, ceph, cx dil
inf., injury
3 Biochemical
fetal scalp Ph
.N ... > 7.25
.borderline ... 7.2-7.25 → Repeat > 20 min
.distress ... < 7.2 → C.S.
fetal pulse oximetry
. change pt position (Lt lat)
. stop ecbolics (⊕ start tocolytic)
. give fluid, O2
. if still distressed: C.S. (if < full dil); Forceps, vent. if full dil, engaged
acute Fetal distress
1 Types
long term .... widely used ... but no improvement in neon. outcome
short term .... 48-72 hrs ... till steroid act & transfer to hospit.
2 Indications
Mother → distress ... PET
Fetus → distress ... IUGR
dis. (PTL) → progress ... > 4 cm, Fully effaced, Rom
contraind for prolongati
3 B2-agonists = Ritodrine Hcl = Yutopar®
50 mg ampoule / 5ml / titration
till contr. disapear ...
Mother
B2 effects with ↑ dose
Fetus
Palpit., ischemia
. arrhythmia
. Pul. edema (if + steroids)
hyperglyc
hyper-insulin
hypoglyc
& hypokalemia
. tachyc. & arrhythmi
↑ B2B
. Hypoglyc.
Hypocalc.
Hyperbili.
MgSO4
. loading 4-6 gm IV / 15-20 min
. maint 1-2 gm IV drip / hour
. excretion Kidney
. follow up - Knee jerk - UOP - Resp. rate
. therap. level 4-7 mEq/L
Toxicity 8-12 ... Knee
12-15 ... Resp
15-30 ... cardiac
Anti-PG
. oral Brufen 25 mg 1x4
. rectal Profenid, indocid 100 mg 1x2
. side effects
Mother: stomach ulcer
fetus: premat. closure of ductus art., oligohydramn.
Ca channel blocker
. loading 10 mg / 20 m. (4 doses)
. maint. 10 mg / 6 hrs
. Adv. ... same efficacy as yutopar & more safe
. Side effect ... hypot, flush, tachy
Steroids
indic ... all HRP → enhance fetal release of surfactant
contraindic: DM, HTN poor control; PROM, RHD inf.
Dose (24 mg) ... Beta 12 mg/24h x2 ... Dexa 6 mg/12h x4
Method .... multiple .... single
< 28 ... 34 >
↓ side effects
1 Oxytocin
. 9 a.a. Nonapeptide: synth. in hypoth, stored in post pit
- late - conts. - safe
uses
. Preg. early .... ind. of ab., ttt of postab. bl.
late .... ripening of cx, ind of labor
. labor 1st ..... augment. of labor, ttt of inertia
3rd .... manag. of 3rd st., ttt of PPhge
. lactation .... may be used as Lactogogue
Comp.
→ over-stim. Mother: R.ut., AFemb.; Fetus: Pl. insuff → distress
→ over-dosage — water intoxic: hyponat; neonatal jaundice
Contraind.
ut. scar, GMP
pl. insuf, f. distress
CPD, p. prev., Tr. lie
absolute
adminstr. titration: 0.5-2 mIU/min → ↑ by 1-2 mIU / 30-60 min
Cordill inf. pump
2 PG analogues
- early - ripening - dangerous
* CX → Ripening of cx & induction of labor
. PG E2 ... prostein, vagiprost 25 ug/4h (4 doses)
"misoprostone" . PG E1 ... Cytotec, misotec
* uterus
* intraut extramn (ind. of ab.)
* intramyometrial (in pphge)
PGF2α
: Contraction
* fetus
. Keeps ductus art. patent
. helps urine production
3 Methergine
ergot alkaloide
tonic
uses (action lasts 4 hrs)
. Abortion .... postab. bl.
. 3rd stage ... atonic pphge
Comp if < fetal delivery → distress; > dose → V.C. → HTN & ischemia
* oral 1mg ... 7 min
* I.M 0.5 mg ... 3.5 m
* I.V 0.25 mg ... 1 m
IUFD
Antenatal :- IUGR
Intranatal :- ⊕ fetal: asphyxia, hge, trauma, inf
Postnatal :- ⊕ PTL
PNMR = still birth + neonatal death / total birth in same year x 1000
F. distress
Ante-natal
Intra-natal
ttt
. Prophyl. ... FWB
. active ... TOP
N. asphyxia
= asphyxia neonatorum
A. livida
A. pallida
Ass. of lung mat.
History .... LMP
clinical ..... f. level
Inv. → U/S: AF turbid, PL calc. grade III
aminocent.
L/S ratio
bubble stability
R. distress synd
type I ... HMD
type II ... TTN
mecon. aspirat.
APGAR score
Apearance
Pulse
Grimace
Attitude
Resp. rate
N. jaundice
Physiological
Patholog.
- Prehepatic
- hepatic
- obstructive
Rh

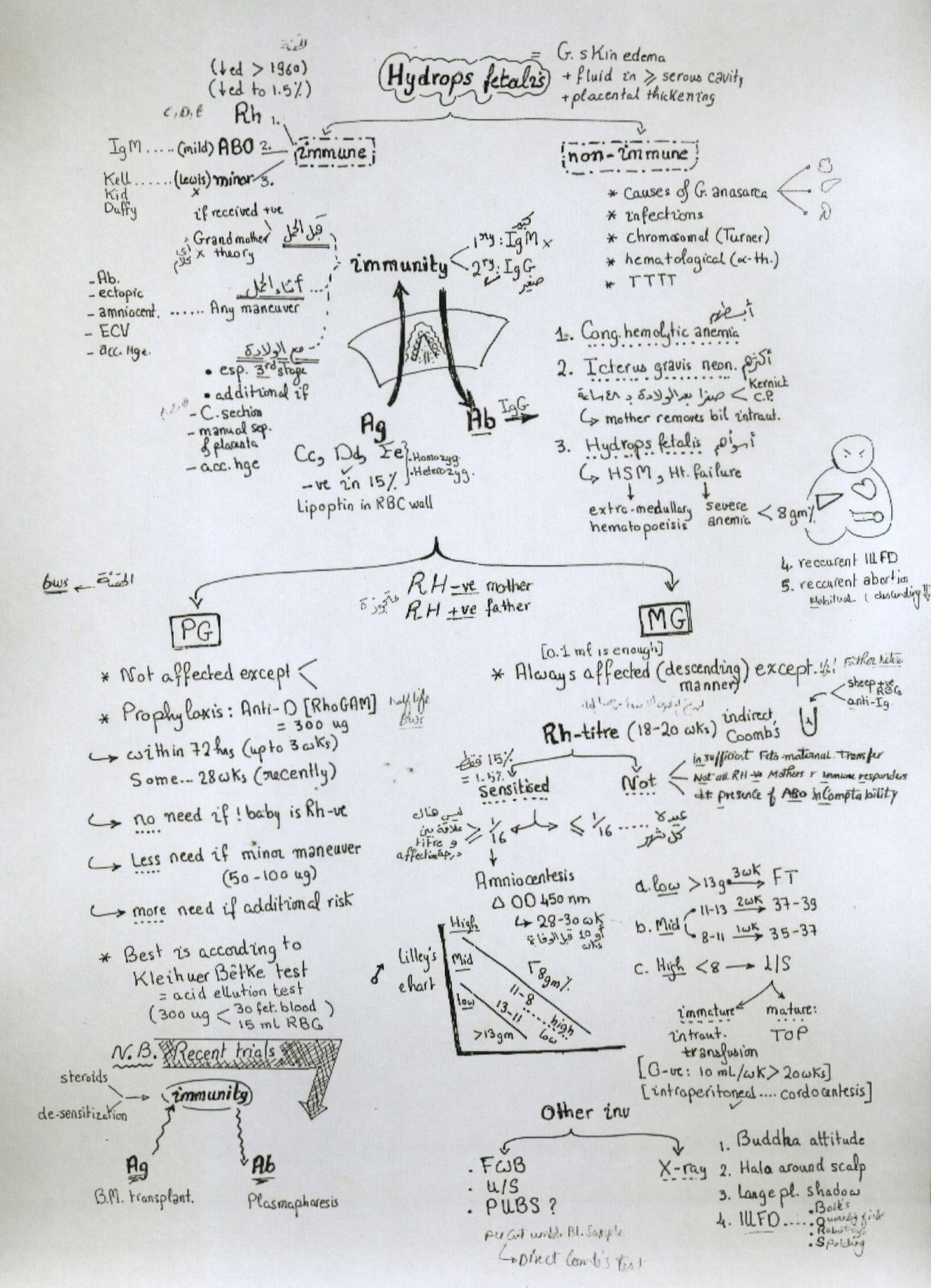
	IUGR 5%	Macrosom 5%	PROM 1-10%	Oligo 0.5%	Poly 0.5%	Preterm 5-10% (= abortion)	Postterm 5-10%
Def.	- B.W. < 10th percentile - Pl. insuff is dt. < maternal / placental	- B.W. > 90th p. > 4.5 or > 4 (D.M.)	Normally 10% < active ut. cont. (PROM) 1% < 37 wks (P PROM) ..... PTL	* clinically ↓ amount * U/S < AF < 0.5L / AFI < 5cm	* clinically ↑ amount * U/S < AF > 2L / AFI > 20cm	Labor < 37 wk > 20/28 (ut) > 6-8/hr, > 4/20m. (Cx) > 2cm dil., > 80% eff.	Preg. > 42nd wk Dysmature < postt. + IUGR
Etiology Idiopathic in 75%	HRP ✓ [M] [P] [F] inf. TTT CFMF	[G] D.M. ✓ M. Obesity Post term E. Fetalis [L]	7i inflation < twin / polyhyd inherent weakness insuff. nut. incompet. Cx I.C., infection, iatrogenic	Post term Pl insuff (PET) PROM CFMF anti-PG. B (Potter)	D.M. chorio-angioma H. fetalis twins CFMF e.g. - open NTD - esoph. atresia - cong. nephrosis g. edema	[1] Spont. [M] [F] [L] twins CFMF H. fetalis AF. infection Polyhyd. PROM prev. [2] induced for M. / F. sake	* wrong dates i.e. Malpresentations * No oxyt. / PG steroids i.e. anencephaly i.e. Long use of Anti PG
C/P [G] history / Exam [A] → FL. / UG. / FHS [L]	↓ weight < < 50 Kg / > 28 wks < amen. (gravidogram) oligohyd. (abd. girth) ± f. distress	↑ weight > amenorrhea {previous history / presence of etiology}	* sudden gush of H_2O vag. fluid : urine / show / D.D. - < amen. - easily felt - easily head / moulded * Never ... except if TOP	± P.E.T. same = PROM → Small bag of fore water	acute: 1/2000, 4-6m. chronic: 1/200, > 28 wk [G] Pr. sympt., Lt. ed., PET [A] Pain, stretch < Fetal parts / FHS [L] cx. partially dilated	[1] Pts at risk - Good ANC < inf. / anemia - Sedative, no SI, rest - Serial (screening) < TVUS (Cx) / Fibronectin - 2 medicine < Prog. + tocolysis esp. < previous PTL / polyhyd., PROM / twins [2] Threatened PTL → false l. pain ⊕ backache → change of ccc of disch. . Hospit. to assess * uterus * CX * fetus palpate monitor Bishop BPP [3] Established PTL * Hospit < rest / hydration * Abcs * tocolytics → B_2 agonists / Ca^{++} blockers / anti-PG / $MgSO_4$ * steroids → Beta 12mg/24 (2 doses) / Dexa 6/12 hr (4 doses) [4] if delivery occured 1st: ABG, vit K, avoid depressant drugs 2nd: epis., forceps, CS if distress / IUGR / breech newborn: special care	LMP ↓ weight. ↓ abd. girth
Inv. A. F.W.B. C. D. Routine E.	- GTT, Storcheb diagnosis (U/S) 2 types [I] < symmet. F [II] < asymmet. P.M. * EGA & U/S * serial U/S	- GTT - (U/S) esp. T.A.D	(History) < urine / show / inf. (sterile cusco) < nitrazine / nile blue / Fern AFI.. (U/S) liquor amount (amniocent.) < t dye / inf. ⊕ CBC FWB	exclude Rom (U/S) → AFI < 5cm, CFMF, post-maturity	GTT (U/S) → AFI > 20 cm, CFMF, Twins → uniov. → Acute		(U/S) → BPD > 10.2, liquor, pl. Gr
Comp. M. → P. P. P. F. → P., P. fetal	.Preg ...... IUFD . Labor < HIE / MAS. . Fetus < hypo - glycemia / calcemia / thermia; polycy... jaund, DVT	Shoulder dyst. ✓ → M ... PPH → F ...	[M] → PTL Chorioam. G ... fever, ↑pulse, ↓ WOP A ... tend., fetal tachyc. L ... purulent disch [F] → peri-natal asphyxia mal p., cord compression Prolonged oligo . lung hypoplasia . Adhesions . Talipes equino	[M] → P_1 → P_2 → P_3 [F] CFMF PTL ✓		[M] 1st 2nd 3rd [F] . asphyxia . injury
ttt 1. Prophylaxis 2. Active → Cons. / TOP 3. Neonate expert	⊕ Proph. Baby aspirin 75mg ⊕ Preg. < I ... TOP / II ... Hospit. 1. ttt of I cause vit E, Amino: 2. Drugs ... aspirin / heparin / steroids 3. follow up → growth (U/S) → maturity (U/S) → FWB + Doppler ⊕ TOP . C.S. . V.D ... CTG	⊕ Proph. - ttt of D.M. - elective C.S. ⊕ Active GFA episiotomy 1. < McRobert / suprapubic P. 2. < Bring down post arm / rotate trunk 3. < Cleidotomy / Symphysiotomy / Zavanelli	(-ve) < 26 ... > 35 (+ve) tocolyt. . PTL or steroid . lung mat. abcs . infection → TOP ↓ Hospit. . fever chart / ... → V.D. → fit for induction / no f. distress . TLC, ESR, CRP → C.S. . remove cerclage . Abcs, extra peritoneal	⊕ Preg → malformed → No / Yes: TOP . follow up f. distress ⊕ amnioinfusion ⊕ Labor: ↑ CS% . prolonged labor . fetal distress . breech	⊕ Acute → TOP by (ARM + oxyt.) Controlled Drew (Role H_2O) Slowly the ⊕ Chronic → First conserv. → TOP if . ttt of I cause → no CFMF improv. . drugs - anti PG . amnioreduction . Follow up - Pr. sympt		[40 wks] → FWB twice/wk . fetal kicks [41 wks] → . fit → / . not → [42 wks] → V.D (PG - ARM - oxyt.) / C.S. ✓

* Full term (37-42w) (80-90%)

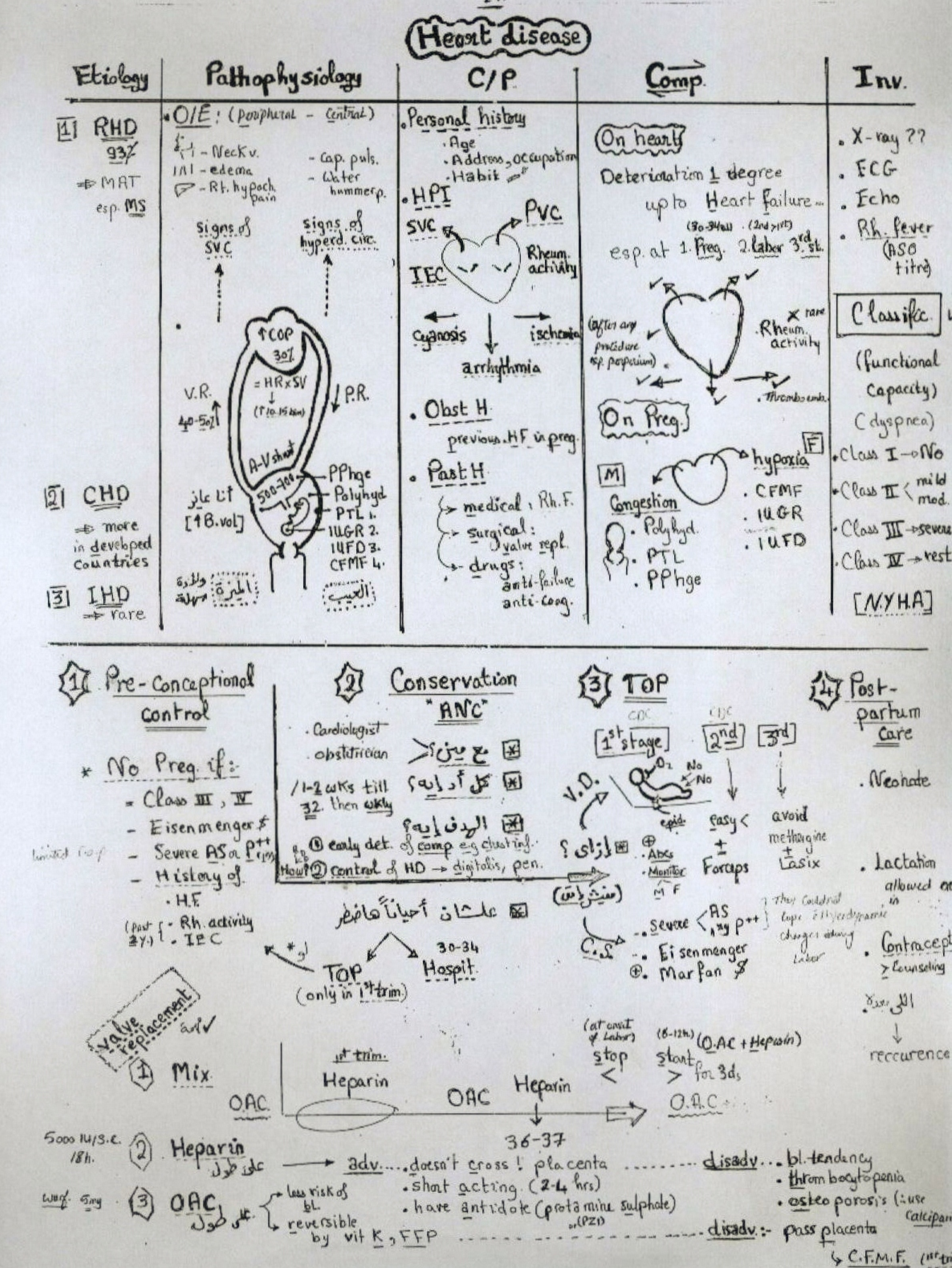
→ only wait 10 days > 40 w



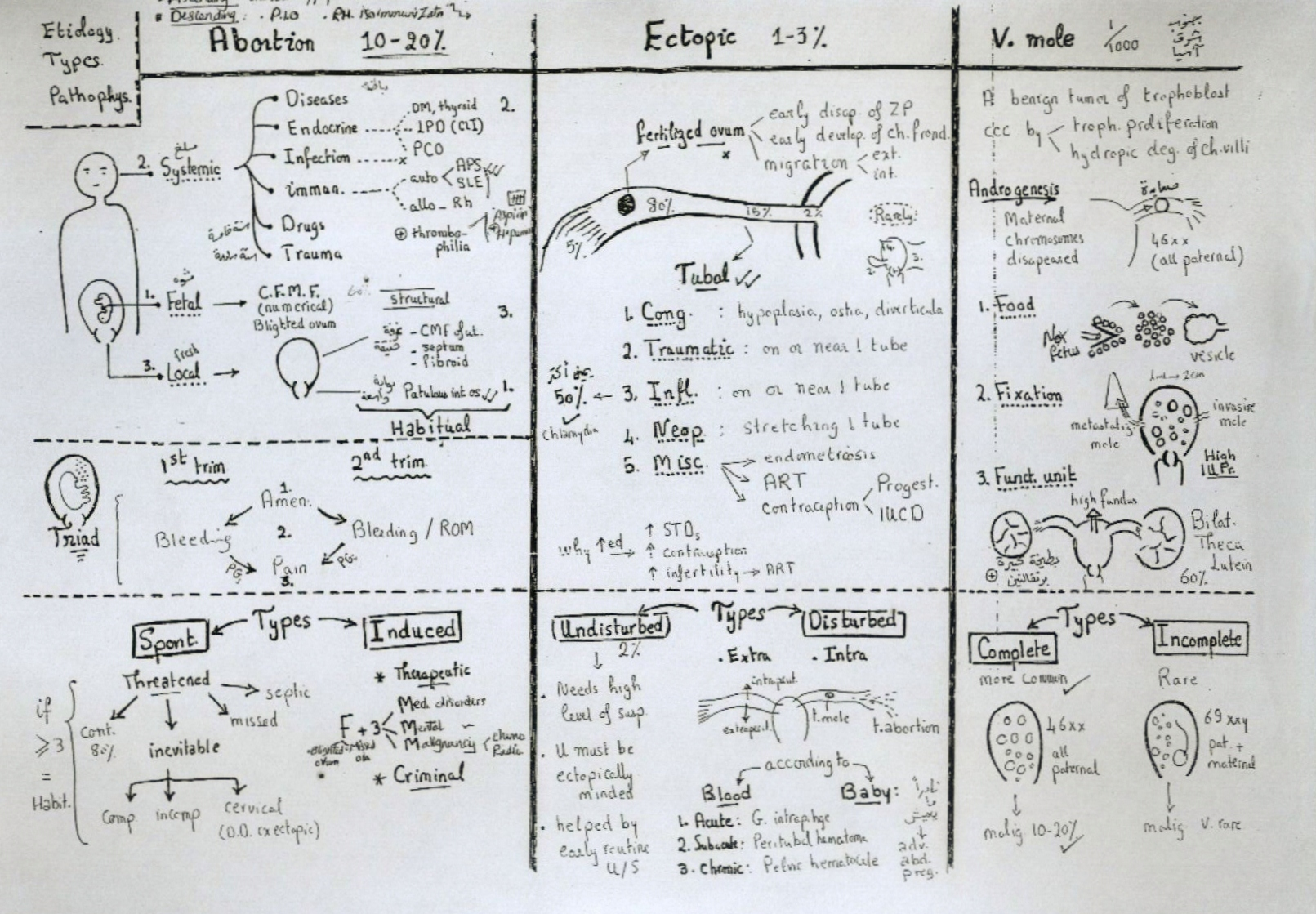
Max. → 7
Twins
1/80
Helin's rule
etiology
1) Race
familial
↑age, ↑parity
2) Hormones
induction
C.O.C.
(Rebound)
1. placenta
2. Am. memb.
3. Fetus
due to fertilization of one ovum by one sperm → constant factor
all over the world = 1/250
identical except in
Finger Prints
Iris Pattern
Voice pattern
Types
Vanishing 20%
8 wks (TVUS)
number 1.
Lambda
Tau
Zygosity 2.
sex
polyhyd.... Comp. 3.
FWB 4.
Doppler
5. Selective embryo-reduction
U/S 5
inv.
إيه فايدة السونار
لكل طفل على حدة
placenta m.b. fused in 50%
DC-DA
1.
2. MC-DA
3. MC-M-A
4. Conjoined
1/3 <4d
2/3 4-8d
5% 8-12d
v. rare >12d
2/3 Binovular
(DiZygotic) (fraternal)
Monovular 1/3 (identical)
(MonoZygotic)
Comp
Prolonged, PROM ← 1st
obst.
locked
1! Acc. hge
2nd
PPhge ← 3rd
S3 ..... P.
M
F
• CFMF
• IUGR ... discordant twin
• PTL
• IUFO ... maybe single fetal demise
20%
• TTTT
IUGR (donor)
H. fetalis (recepient)
• Cord entanglement
acute polyhydramnios
• Conjoined twin
C/P
25% missed
G.
excess weight
↓↓ edema
± PET
A.
— palpation
• FL > amen.
• multiple poles
• delayed engag.
— auscultation
• 2 FHS heard
بواسطة دكاترة
• Arnaux sign
(gallop rhythm)
L.
"during labor"
— slow cx. dil.
large bag of H2O
• PROM
• cord prolapse
small present. part
ttt
Preg.
Lab.
Diet
Rest
followup
proph. cerclage
steroids
tocolytics
1st stage ---- guard against
PROM
Sepsis
2nd stage
twin A ---- episiotomy ✓, min. interference
after its delivery --- no methergine x, exclude cord prolapse.
twin B → . Cephalic
spont. delivery (20-30 min.)
if distressed @ > 20 min
- engaged → forceps/ventouse
- non-engaged → IPV & br. ext.
3rd stage
- guard against PPhge
إزاي تفرق الاتنين من بعض؟
1. babies sex, group, HLA
2. Placenta
2 ... binov. & 1/3 monov.
1 ... binov. & 2/3 monov. (fused)
• breech
spont. br. delivery
if >20 min or distressed → Br. extraction
• transv. — IPV & br. extraction.
C/S
1. Monoamniotic
1st non-vertex
2nd twin retained
3 babies or more
locked twin
conjoined twin



Hydrops fetalis
= G. skin edema
+ fluid in ≥ serous cavity
+ placental thickening
(↓ed > 1960)
(↓ed to 1.5%)
C, D, E
Rh 1.
IgM ..... (mild) ABO 2.
immune
Kell ...... (Lewis) minor 3.
Kid
Duffy
non-immune
* Causes of G. anasarca
* infections
* chromosomal (Turner)
* hematological (α-th.)
* TTTT
if received +ve
Grandmother theory
- Ab.
- ectopic
- amniocent. ...... Any maneuver
- ECV
- acc. hge.
• esp. 3rd stage
• additional if
- C. section
- manual sep. of placenta
- acc. hge
immunity
1ry: IgM
2ry: IgG
Ag
Ab
IgG
Cc, Dd, Ee
- Homozyg.
- Heterozyg.
-ve in 15%
Lipoptin in RBC wall
1. Cong. hemolytic anemia
2. Icterus gravis neon.
Kernict
C.P.
mother removes bil intraut.
3. Hydrops fetalis
HSM, Ht. failure
extra-medullary hematopoeisis
severe anemia < 8 gm%
4. reccurent IUFD
5. reccurent abortion
RH -ve mother
RH +ve father
PG
MG
* Not affected except
* Prophylaxis: Anti-D [RhoGAM] = 300 ug
half life
within 72 hrs (up to 3 wks)
Some... 28 wks (recently)
no need if ! baby is Rh-ve
Less need if minor maneuver (50 - 100 ug)
more need if additional risk
* Best is according to Kleihuer Betke test = acid ellution test
(300 ug < 30 fet. blood / 15 ml RBC)
N.B. Recent trials
steroids
de-sensitization
immunity
Ag
Ab
B.M. transplant.
Plasmapharesis
[0.1 ml is enough]
* Always affected (descending manner) except
father hetero
sheep +ve RBCs
anti-Ig
Rh-titre (18-20 wks) indirect Coombs
15% = 1.5%
Sensitised
Not
insufficient Feto-maternal transfer
Not all RH -ve Mothers r immune responders
d.t. presence of ABO incompatibility
≥ 1/16
≤ 1/16
Amniocentesis
Δ OD 450 nm
28-30 wk
Lilley's chart
High
Mid
Low
8 gm%
11-8
13-11
>13 gm
high
low
a. low > 13 g —3 wk→ FT
b. Mid 11-13 —2 wk→ 37-39
8-11 —1 wk→ 35-37
c. High < 8 → I/S
immature
intraut. transfusion
mature: TOP
[O-ve: 10 mL/wk > 20 wks]
[intraperitoneal .... cordocentesis]
Other inv
. FWB
. U/S
. PUBS ?
X-ray
1. Buddha attitude
2. Halo around scalp
3. Large pl. shadow
4. IUFD
. Ball's
. Robert's
. Spalding
Direct Coomb's test

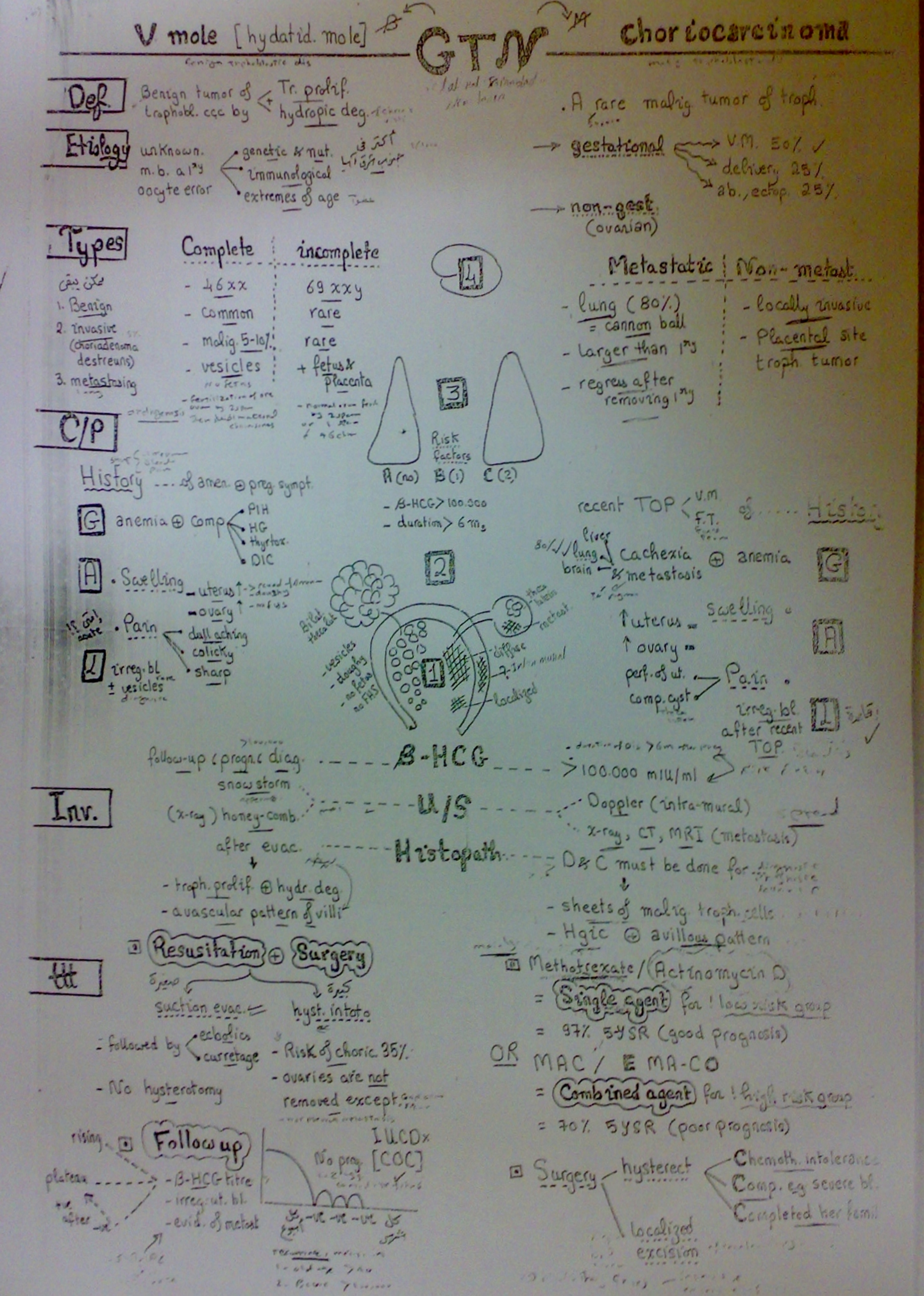


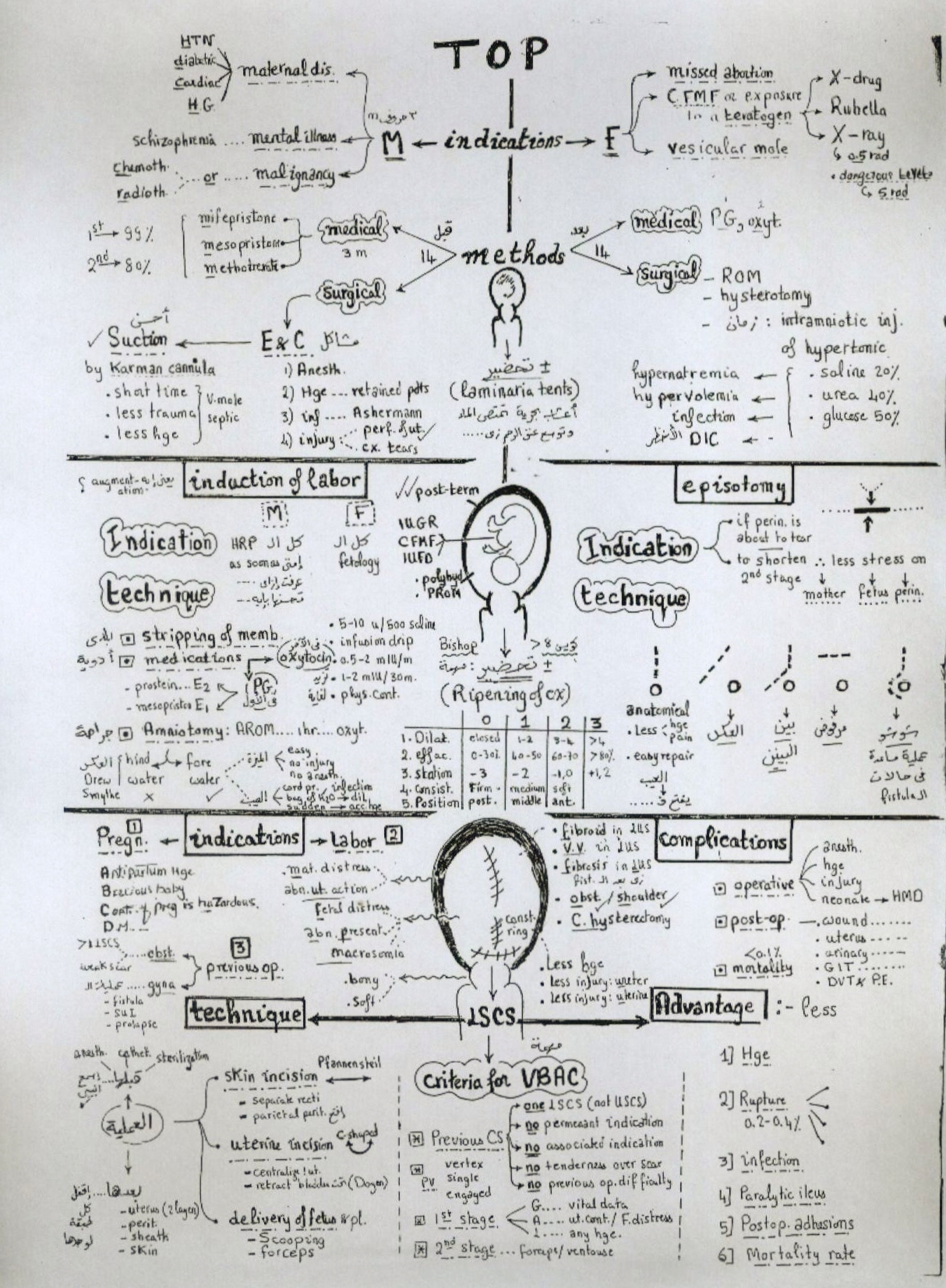
1%
Heart disease
Etiology
Pathophysiology
C/P
Comp.
Inv.
1 RHD 93%
MAT esp. MS
O/E: (peripheral - central)
Neck v.
edema
Rt. hypoch. pain
cap. puls.
Water hummer p.
Signs of SVC
Signs of hyperd. circ.
↑COP 30%
= HR x SV
V.R. 40-50%
P.R.
A-V shunt
[↑B.vol]
PPhge
Polyhyd
PTL 1.
IUGR 2.
IUFD 3.
CFMF 4.
Personal history
Age
Address, occupation
Habit
HPI
SVC
PVC
IEC
Rheum. activity
Cyanosis
ischemia
arrhythmia
Obst H
previous HF in preg.
Past H
medical, Rh.F.
surgical: valve repl.
drugs: anti-failure anti-coag.
On heart
Deterioration 1 degree up to Heart failure
esp. at 1. Preg. 2. labor 3rd st.
Rheum. activity
Thromboemb.
On Preg.
M
F
hypoxia
Congestion
Polyhyd.
PTL
PPhge
CFMF
IUGR
IUFD
X-ray ??
ECG
Echo
Rh. fever (ASO titre)
Classific.
(functional capacity)
(dyspnea)
Class I → No
Class II mild mod.
Class III → severe
Class IV → rest
[NYHA]
2 CHD
more in developed countries
3 IHD
rare
1 Pre-conceptional control
* No Preg. if:
- Class III, IV
- Eisenmenger S
- Severe AS or P++
- History of.
· H.F
· Rh. activity
· IEC
2 Conservation "ANC"
Cardiologist
obstetrician
/1-2 wks till 32 then wkly
early det. of comp e.g. clustering.
control of HD → digitalis, pen.
TOP (only in 1st trim)
30-34 Hospit.
3 TOP
1st stage
2nd
3rd
V.D.
O2
epid.
Abcs
Monitor MF
easy
Forceps
avoid methergine
Lasix
C.S
Severe AS, P++
Eisenmenger
Marfan S
4 Post-partum care
Neonate
Lactation allowed
Contracept
Counseling
reccurence
Valve replacement
1 Mix
OAC
1st trim.
Heparin
OAC
Heparin
36-37
stop
start for 3ds
O.AC + Heparin
O.A.C
2 Heparin
5000 IU/S.C. 18h.
adv. doesn't cross placenta
short acting (2-4 hrs)
have antidote (protamine sulphate)
disadv. bl. tendency
thrombocytopenia
osteoporosis
3 OAC
warf. 5mg
less risk of bl.
reversible by vit K, FFP
disadv.: pass placenta
C.F.M.F.



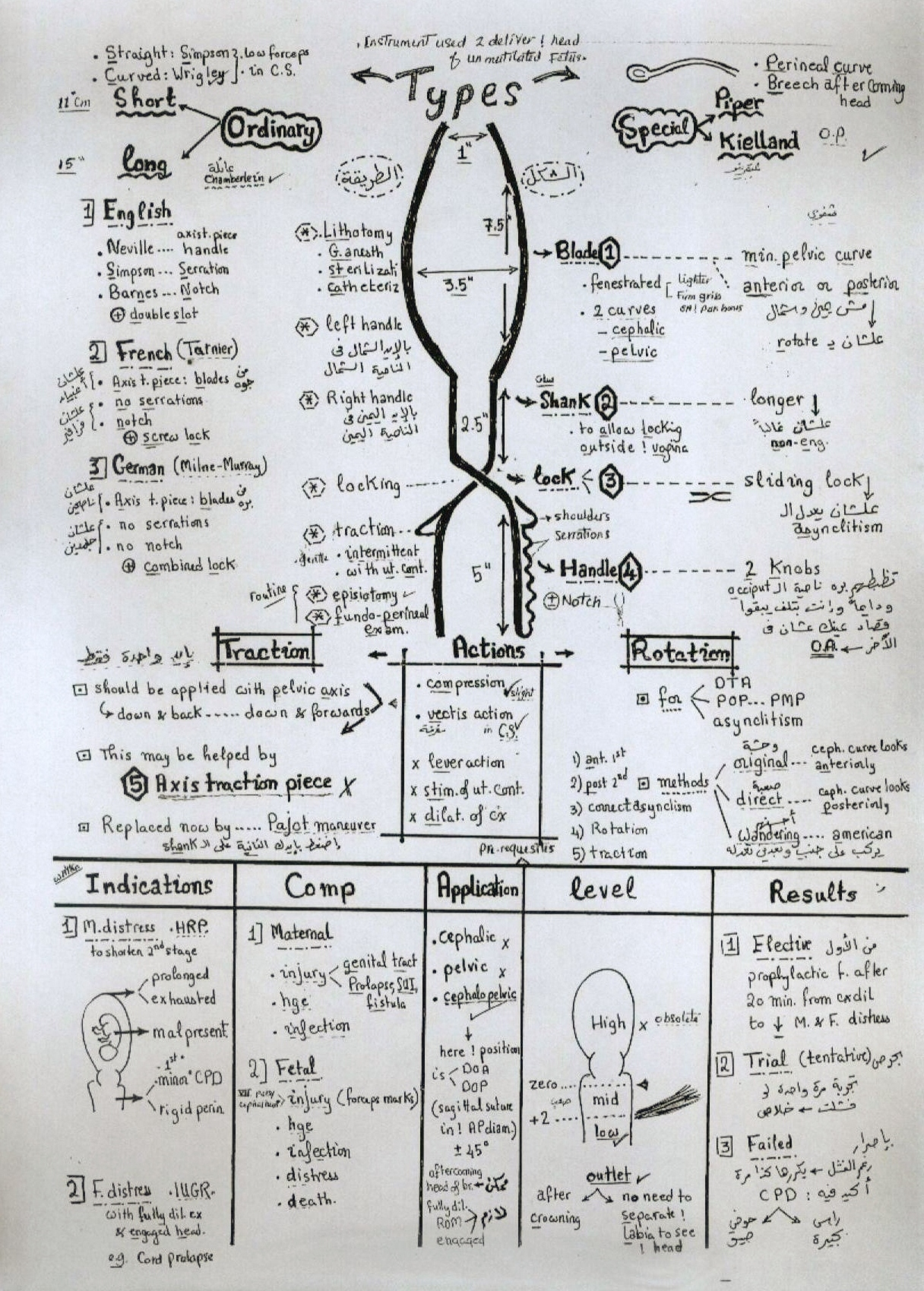
Descending : P.LO . RH. Isoimmunization
Etiology.
Types.
Pathophys.
Abortion 10-20%
Ectopic 1-3%
V. mole 1/1000
2. Systemic
Diseases
Endocrine
Infection
immun.
Drugs
Trauma
DM, thyroid
LPD (CLI)
PCO
auto APS SLE
allo - Rh
⊕ thrombophilia
Aspirin
Heparin
1. Fetal
C.F.M.F. (numerical)
Blighted ovum
60%
structural
3. Local
- CMF of ut.
- septum
- fibroid
Patulous int os
Habitual
1st trim
2nd trim
Triad
Amen.
Bleeding
Bleeding / ROM
Pain
PGs
Types
Spont.
Induced
Threatened
septic
missed
Cont. 80%
inevitable
Comp
incomp
cervical (D.D. cx ectopic)
if ≥3 = Habit.
* Therapeutic
Med. disorders
Mental
Malignancy
Chemo
Radio.
F+3
Blighted ovum
Missed ab.
* Criminal
fertilized ovum
early disap. of ZP
early develop. of ch. frond.
migration
ext.
int.
80%
15%
2%
5%
Rarely
Tubal
1. Cong. : hypoplasia, ostia, diverticula
2. Traumatic : on or near the tube
3. Infl. : on or near the tube
50%
Chlamydia
4. Neop. : stretching the tube
5. Misc.
endometriosis
ART
contraception
Progest.
IUCD
why ↑ed
↑ STDs
↑ contraception
↑ infertility → ART
Types
(Undisturbed)
2%
Needs high level of susp.
U must be ectopically minded
helped by early routine U/S
Disturbed
. Extra
. Intra
intraperit.
extraperit.
t.mole
t.abortion
according to
Blood
Baby
1. Acute: G. intraperit. hge
2. Subacute: Peritubal hematoma
3. Chronic: Pelvic hematocele
adv. abd. preg.
A benign tumor of trophoblast
ccc by
troph. proliferation
hydropic deg. of ch.villi
Androgenesis
Maternal chromosomes disappeared
46xx (all paternal)
1. Food
No fetus
vesicle
2. Fixation
metastatic mole
invasive mole
High HCG
3. Funct. unit
high fundus
Bilat. Theca Lutein
60%
Types
Complete
Incomplete
more common
Rare
46xx all paternal
69 xxy pat. + maternal
malig 10-20%
malig V. rare

	Threatened	Inevitable	Missed	Septic	Undist.	Disturb.	V. mole
Def.	Partial separation of fert. ovum from ut. wall	comp. separation ↓ fetal expulsion	Retained non-viable fetus	Super imposed inf. • G+ve: GBS • G-ve: E.coli • Aner.: clostr	early diagnosis < rupture	Rupture occured	Benign GTD
Sympt. 1. Amen 2. BL 3. Pain	 +ve slight slight	 +ve severe (+ colick) severe (+ backache)	 +ve No bl. → Br. disch. No pain → absent f. Kicks	All are present followed by sympt. of inf. → FAHM-R → cont. lower abd pain → offensive disch.	- Short period of amen. (usually one missed period) - slight pain - no bleeding	5-6 wk . short / absent . sudden severe pain ↳ collapse . no/slight bL.	- Amen. (but no f. Kicks) - BL ± vesicles (diagnostic) - Pain < dull aching, colicky, sharp ± acute ?! abd.
Signs 1. G. 2. Abd 3. PV	 signs of preg. = F.L. cx: closed	 Pallor/shock = F.L cx: opened	 No signs of preg. ↓ F.L. cx: < closed ± Prune juice	 Toxic look . Tender uterus Pelvic abscess/ physometra	- Signs of preg. (ed.) - uterus slight ⇧ - mild tenderness or small adnexal swelling (C.L. of preg.)	- Shock not proport. to ext. bL - T, R, RT < Cullen, shifting . Tender adnexum = jumpin sign ✓	- Pallor / shock ± Comp. - ut > FL < doughy; no FHS < twins, partial; bilat. TL cyst - vesicles
Inv. B.HCG u/s → etiology → comp.	+ve: doubles/2d. +ve ↳ TV 5 wk ↳ TA 7 wk ↳ Sonicaid 10	clinically diagnosed {U/S} comp. / incomp.	→ no doubling → no fetal pulsation Fibrinogen ✓	U/S < dead fetus, incomp. abortion → < blood: ESR, TLC; high vag. swab → DIC... Renal funct.	B-HCG: subnormal rise < 66%, ممكن تبقى thr. ab. TVUS: small sac outside ! ut., ممكن تبقى C.L. + Aria Stella ↘ Combination ↙	Clinically diagnosed → Hct level	• B-HCG > 100.000 (& for follow up) • U/S .... snow storm • X-ray < Honey comb; no fetal skeleton; chest: Cannon-ball
Comp.	* Continues 70-80% * OR → inf., dies, BL↑	- Hge - inf. - injury → perforation in D&C	• DIC < 100 mg% ↳ slowly 50/wk ↳ heparin may be given (twins) • Sepsis	SIRS معركة	Disc. zone = 2000 لو < Laparoscope ✓, culdocentesis x	Shock	General: - PIH < 20 wk; - HG; - thyrotox.; - Pul. emb. Local: - Hge, inf; - Malig.; - Perforation; - Reccurence
ttt.	☒ Conservation 3 < Rest, Fe, anti-d 3 < anti-PG ✓, Progest ✓, B_2 agonist x ☒ TOP if	☒ Rescusit. 1st: .suction .D&C 2nd: .oxyt. .PG ☒ followed by .ecbolics .antibiotics	☒ According to fibrinogen > 100 → TOP (1st, 2nd) < 100 → correct first: • fibrinogen • FFP • Fresh bl.	① elevate G. cond. Antibiotics < high dose, combin. ICU, CVP ② TOP < suction ✓, hysterotomy, hysterect. late ③ Comp	☒ Laparoscopy ✓ or Laparotomy - Salpingectomy ✓ - Salpingotomy < PG, mild cases, one tube present ☒ Medical = methotrexate . < 3 cm, < 3000 . no ♡ pulsation . vitally stable 50 mg/m^2 I.M.	Rescusit. ↓ Laparotomy ↓ Salpingectomy . D&C ± . RH ±	Rescusit. Suction evac. then → ecbolics ↳ curretage (> 35, malig. 35%) Hysterect. but → Leave ! ovaries Follow up: 2-3 m., 6-12 m., C.O.C. (no IUCD), wk -ve -ve -ve (month)


V mole [hydatid. mole]
GTN
Choriocarcinoma
Def.
Benign tumor of trophobl. ccc by
Tr. prolif.
hydropic deg.
Etiology
unknown.
m.b. a 1ry oocyte error
genetic & nut.
immunological
extremes of age
Types
1. Benign
2. invasive (choriadenoma destreuns)
3. metastasing
Complete
incomplete
- 46 xx
- common
- malig. 5-10%
- vesicles
69 xxy
rare
rare
+ fetus & placenta
C/P
History --- of amen. ⊕ preg. sympt.
G
anemia ⊕ comp.
PIH
HG
thyrtox.
DIC
A
Swelling
uterus ↑
ovary ↑
Pain
dull aching
colicky
sharp
L
irreg. bl
± vesicles
. A rare malig. tumor of troph.
→ gestational
V.M. 50%
delivery 25%
ab., ectop. 25%
→ non-gest (ovarian)
4
Metastatic
Non-metast
- lung (80%) = cannon ball
- larger than 1ry
- regress after removing 1ry
- locally invasive
- Placental site troph tumor
3
Risk factors
A (no)
B (1)
C (2)
- B-HCG > 100.000
- duration > 6 ms
recent TOP
V.M
F.T.
of ...... History
liver
lung
brain
cachexia & metastasis
⊕ anemia
G
↑ uterus
↑ ovary
Swelling
A
perf. of ut.
comp. cyst
Pain
irreg. bl after recent TOP
L
2
1
- vesicles
- doughy
- no fetus
- no FHS
diffuse
intra mural
localized
Inv.
follow-up c progn. c diag.
B-HCG
> 100.000 mIU/ml
snow storm
(x-ray) honey-comb
U/S
Doppler (intra-mural)
x-ray, CT, MRI (metastasis)
after evac.
Histopath
D & C must be done for
- troph. prolif. ⊕ hydr. deg.
- avascular pattern of villi
- sheets of malig. troph. cells
- Hgic ⊕ avillous pattern
tt
Resusitation ⊕ Surgery
suction evac.
hyst. in toto
- followed by
ecbolics
curretage
- Risk of choric. 35%
- No hysterotomy
- ovaries are not removed except
Methotrexate / Actinomycin D
= Single agent for ! low risk group
= 97% 5-YSR (good prognosis)
OR
MAC / EMA-CO
= Combined agent for ! high risk group
= 70% 5YSR (poor prognosis)
rising
plateau
Follow up
- B-HCG titre
- irreg. ut. bl.
- evid. of metast
IUCDx
No preg. [COC]
Surgery
hysterect
Chemoth. intolerance
Comp. eg severe bl.
Completed her famil
localized excision



	0	1	2	3
1. Dilat.	closed	1-2	3-4	>4
2. Effac.	0-30%	40-50	60-70	>80%
3. Station	-3	-2	-1,0	+1,2
4. Consist.	Firm	medium	soft	
5. Position	post.	middle	ant.	



Instrument used 2 deliver ! head of unmutilated Fetus.
Types
Straight: Simpson
Curved: Wrigley
low forceps in C.S.
11 cm
Short
Ordinary
long
15"
Chamberlein
عائلة
1 English
Neville .... axist. piece handle
Simpson ... Serration
Barnes ... Notch
⊕ double slot
2 French (Tarnier)
Axis t. piece: blades
no serrations
notch
⊕ screw lock
3 German (Milne-Murray)
Axis t. piece: blades
no serrations
no notch
⊕ combined lock
الطريقة
الشكل
1"
7.5"
3.5"
2.5"
5"
Lithotomy
G. anesth
sterilizati
catheteriz
left handle
بالإيد الشمال فى الناحية الشمال
Right handle
بالإيد اليمين فى الناحية اليمين
locking
traction
intermittent
with ut. cont.
routine
episiotomy
fundo-perineal exam.
Blade 1
fenestrated
lighter
Firm grip
2 curves
cephalic
pelvic
min. pelvic curve
anterior or posterior
rotate
Shank 2
to allow locking outside ! vagina
longer
non-eng.
lock 3
sliding lock
asynclitism
shoulders
Serrations
Handle 4
⊕ Notch
2 Knobs
occiput
OA
Special
Piper
Perineal curve
Breech after coming head
Kielland
O.P.
Actions
compression slight
vectis action in C.S.
x lever action
x stim. of ut. cont.
x dilat. of cx
Pr. requesites
Traction
should be applied with pelvic axis
down & back ..... down & forwards
This may be helped by
5 Axis traction piece x
Replaced now by ..... Pajot maneuver
Rotation
for
OTA
POP ... PMP
asynclitism
1) ant. 1st
2) post 2nd
3) correct asynclism
4) Rotation
5) traction
methods
original ... ceph. curve looks anteriorly
direct ... ceph. curve looks posteriorly
Wandering ... american
Indications
Comp
Application
level
Results
1 M. distress . HRP
to shorten 2nd stage
prolonged
exhausted
malpresent
1st. minor CPD
rigid perin
2 F. distress . IUGR
with fully dil. cx & engaged head.
e.g. Cord prolapse
1 Maternal
injury
genital tract
Prolapse, SUI, fistula
hge
infection
2 Fetal
injury (forceps marks)
hge
infection
distress
death.
cephalic x
pelvic x
cephalopelvic
here ! position is
DOA
DOP
(sagittal suture in ! AP diam)
± 45°
after coming head of br.
fully dil.
ROM
engaged
High x obsolete
zero
+2
mid
low
outlet
after crowning
no need to separate ! labia to see ! head
1 Elective
prophylactic f. after 20 min. from cx dil to ↓ M. & F. distress
2 Trial (tentative)
3 Failed
CPD